Are poor women more likely to receive disrespectful and abusive care during facility-based childbirth?

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ABSTRACT

Background Financial and geographical barriers hamper progress for improving access to skilled maternity care. Moreover fear of disrespect and abuse (D&A) perpetuated by health workers influences women’s decisions to seek care leading to low uptake of maternity services. Manifestations of D&A include: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in facilities. Despite acknowledgement of these behaviors by policy makers, programmers, civil society, and communities, the problem appears widespread. Methods A cross-sectional survey conducted in thirteen facilities in Kenya measured the prevalence of types of D&A among 641 postpartum women. Socio-economic status (SES) was assessed using an index generated from household assets/amenities using principle component analysis. The effect of SES was conducted by comparing any occurrence of D&A with five different wealth quintiles. Chi square test was used to compare differences in proportion of reported D&A incidents with the quintiles. Results Women (20%) reported feeling humiliated/disrespected during labour and/or delivery. D&A manifestations included: non-dignified care (18%), neglect (14%), non-confidential care (9%), detention (8%), physical abuse (4%) and bribe demands (1%). Women with a partner/companion during delivery were less likely to experience inappropriate demands for payments or detention; OR: [0.49 (0.26, 0.95); p=0.037]. SES levels compared with any D&A did not yield significant findings. However comparing the poorest 20% with the richest 20%, significant differences [p<0.001] were noted. The poorest women reported: feeling abandoned (16% versus 6%); detained for non-payment (5.5% vs. 12.4%); but no physical abuse (0% vs. 2.3%); or request for bribe (0% vs. 0.8%). Discussion/conclusion Women delivering in public health facilities are not well off; analyzing inequity using quintiles masks findings. Differences were found between the highest and lowest wealth quintiles, but other factors may contribute women's experiences and therefore it is important to think beyond SES to ensure pregnant women receive comprehensive equitable maternity care.
Changing patterns of terminology related to universal health coverage

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ABSTRACT

Background: Implementation of universal health coverage (UHC) has become a public health priority and is the focus of a United Nations resolution passed in 2012. However, terminology related to this topic is varied and often has multiple, and sometimes conflicting, meanings. Building consistency and consensus in this field first requires understanding of the terminology, definitions and patterns related to use in previous literature and case studies. Methods: A citation analysis and systematic literature review using search engines including PubMed, Google Scholar, and Scopus, were conducted to select influential publications related to UHC. Results: Our search produced a database of 363 articles on UHC. When we ranked articles based on citation frequencies by every decade since 1980, the number of articles that were related to UHC increased exponentially recently, especially from 2010. Our systematic literature review showed that recent discussion of UHC broadened the global health agenda from a disease-based approach to a health system-based approach. At the same time, both developed and developing countries are included in its application. In terms of definitions, the meaning of the terminology evolved over the past two centuries, resulting in greater distinction between terms such as 'national health insurance' and 'universal coverage.' Additionally, the frequency in which terms related to UHC were used in peer-reviewed publications greatly increased beginning in the decade of 2000 and the term 'national health insurance' was most frequently used in all decades. Conclusion: Literature over the past 60 years focuses heavily on insurance funding as opposed to equity of access. However, changes related to the way certain terms are defined and their frequency of use suggests a recent paradigm shift. To achieve improved health equity and rights, the authors advocate for use of a definition that addresses all aspects of access, such as the World Health Organization's definition.
Closing the pain divide: A justice perspective

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ABSTRACT

One of the gravest health injustices is the pain divide - the limited, or in many cases lack of, pain control amongst the poorer factions of society. During the age of second generation health reforms, mHealth and other innovative health solutions, it is appalling to consider that millions globally suffer excruciating pain when affordable and effective means exist to palliate. The neglected issue of pain control and palliative care raises the question of whether there is sufficient practical reasoning on justice in public health. Comparative health systems analyses across various dimensions of justice can offer valuable insight within the context of meeting broader requirements of social justice. This paper presents preliminary findings, focusing on the dimension of dignified life and death, from a broader mixed-methods multi-country study comparing which health systems are more or less just. India, a country with the second largest population and one of the largest drug manufacturing industries in world, has some of the worst indicators of access to pain relief. Uganda, far poorer in per capita GDP, is making strides towards establishing a national oral morphine production program through partnerships with international non-profits. Costa Rica, in contrast, is one of few low income countries with universal access to comprehensive palliative care. As such, each country ranks starkly differently when using a multidimensional tool developed to assess the level of justice achieved by a health system. Such rankings from these and other countries can promote public discourse on critical issues of health justice. Using this evidence, the paper concludes with recommendations for policy-makers on targeting health system reform to alleviate the needless suffering of their populations from pain. Further, it offers policy implications for applying ethical reasoning in health systems strengthening.
Equity in maternal health care services in post-conflict Northern and non-conflict East-Central Uganda:
A comparative mixed methods multi-case study

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ABSTRACT
Background Weak health systems in fragile states constrain global progress on the MDGs. Uganda won't achieve the 5th MDG by 2015. Uganda's Northern Region that emerged from a 23 year civil war in 2006 is recognised as a major contributor to the country's poor performance in maternal health. Evidence indicates that there is poor utilisation of maternal health care (MHC) services by people resettling home from internally displaced people's camps. Financial and technical input by the Ugandan Government and its Donors into Northern Uganda has not yet led to health or social welfare improvements. Methods A study using a mixed-method, multi-case approach is just starting, comparing the benefit incidence of MHC funded by government and its developmental partners for women of differing socioeconomic status in the post-conflict region and in a non-conflict region (East Central Uganda), during the immediate post-conflict period 2006-2011. The influence of stakeholders in maternal health policy and governance will be evaluated. Results Benefit incidence is a function of MHC utilisation and its cost at service delivery level. Uganda demographic and health surveys for 2006 and 2011 will determine utilisation rates of MHC amongst women of varying socioeconomic status in the two regions. Costing studies for health facilities under the tiered decentralised health care system and Health Management Information System secondary data for that period will determine the MHC costs at various levels of care. Benefit incidence and determination of variables associated with disparities in utilisation of publicly funded maternal health will be analysed using concentration indices, Lorenz concentration curves and multiple regression analysis. Analysis of interviews and meetings held with MHC policy stakeholders will develop understandings of governance, implementation at regional, district and community levels. Conclusion The study findings will inform national and donor health policy on the rebuilding of equitable health systems for disrupted populations.
Effectiveness of Plan Sesame in achieving equity in healthcare access for elders in Senegal: A social exclusion perspective

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ABSTRACT

Background Ageing in Africa has far-reaching consequences for health systems that are often unable to provide age-appropriate healthcare to older people. A few African countries have developed Social Health Protection (SHP) programmes that aim to reduce healthcare-related vulnerability that affects this group. One such scheme is Plan Sesame in Senegal, a national user-fee exemption that was launched in 2006. We evaluate this scheme from a Social Exclusion (SE) perspective. We explore how exclusionary processes occurring across multiple dimensions - Social, Political, Economic and Cultural - impede access to the programme and affect equity in healthcare access. Methodology We triangulated results from a household survey with analysis of in-depth interviews with key Plan Sesame stakeholders to investigate the observed gradient in activation of the SHP benefits. Ordered logistic regressions were conducted to investigate profiles and characteristics of three main groups: those exempted vs. those who accessed healthcare but did not benefit from exemption vs. those who needed care but did not access. Qualitatively, we investigated the processes that explain exclusionary processes along this utilisation gradient. Key findings Survey results show that less than 5% of older people in need of healthcare services were effectively exempted. Poor policy design and implementation accentuated strong inequitable patterns which were evident across the three groups, with factors like wealth, education, access to media, living in urban areas and political participation, consistently increasing the odds of accessing services and of benefiting from the plan. Qualitative analysis indicates that, beyond the issue of implementation gaps, exclusionary processes explain the observed gradient in access to public resources. It reveals causes rooted in the social and political environment that generates such processes - e.g. internalized discrimination and institutional segregation. Conclusion SHP programmes are unlikely to affect inequity patterns if they do not tackle exclusionary, crosscutting processes at play beyond the health system. Several recommendations are made in that sense.
Effect of women's empowerment and socioeconomic status on choice and use of family planning methods in Sub-Saharan Africa (SSA)

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ABSTRACT

BACKGROUND The determinants of family planning use have been well established in different contexts. However, less is known about the associations between method choice and women's empowerment in general. With the deadline to achieving the Millennium Development Goals (MDGs) fast approaching, most governments and development partners are focusing on finding the best and cost effective ways to meet these and related targets affecting the well-being of women and their families. Over the past couple of decades while some countries in Sub-Saharan Africa (SSA) have seen a modest increase in family planning uptake and concomitant decline in fertility rates, the majority of the countries in the region still struggle to lower fertility rate and increase use of contraceptive prevalence METHODS This study proposes to examine different aspects of women's empowerment and their individual and collective influence on current family planning methods choice in SSA. Demographic and Health Surveys data is used to test a hypothesis that less empowered women tend not to practice family planning methods, and when they do so, are more likely to use permanent methods or methods that do not require men's awareness and involvement. An Ordinal Multivariable Sample-Selection Model will be employed to model this two-stage contraceptive use behavior. RESULTS/DISCUSSION Preliminary results show strong association between women's empowerment and choice of family planning measure. Women's empowerment and ability to have a say in fertility preference has strong association with use and choice of family planning methods across countries in SSA. Scope for women to engage in sexual negotiation is limited in most countries across SSA and serves as a significant determinant for use and choice of family planning methods in some countries. Results also highlight importance of socioeconomic status of women in choosing a specific method of family planning and have a say regarding fertility preferences.
Civil society coalitions for universal health coverage: Challenges and solutions

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ABSTRACT

Universal health coverage (UHC) has emerged as a political movement at the global level, as well as in many low- and middle-income countries where health coverage is low and out-of-pocket spending is high. Yet this movement has been driven principally by technical organizations, particularly the World Bank, World Health Organization and Pan-American Health Organization. Civil society organizations have been quiet on UHC at the country level and, in some cases, perceived as obstructing its progress at the global level. This divide has undermined the claim that UHC responds to public demand, possibly diminishing its standing among potential post-2015 United Nations development goals. While this dynamic persists, it can be corrected. This presentation draws upon the experience of two civil society campaigns: a global campaign of civil society organizations for UHC in the post-2015 framework and a campaign for UHC in three sub-Saharan African countries (Ethiopia, Kenya, Nigeria). Each campaign was designed to galvanize civil society support around UHC, among other objectives. The post-2015 campaign, in particular, mapped the positions of health sector NGOs in order to develop a statement of principles which would draw the broadest possible coalition. This exercise recommended a focus on equity, human rights, and harmonization with multisectoral health efforts. This presentation will expand on the process of constituency mapping and other challenges and solutions in UHC coalition-building at both the global and country level.
Model development for consumer service center to moderate complaints in hospitals registered under the universal health coverage scheme in Thailand

Prongfa, Piyanuch

National Health Secu

ABSTRACT

Background Complaint Management Center has been set up at National Health Security Office (NHSO) to protect patients right under the Universal Coverage Health Insurance Scheme. Patients can make a complaint when facing any inconvenience or any problems from health care delivery system regarding their rights. Preliminary data analysis shows that most of complaints occur from mis-communication between providers and consumers causing to poor doctor-patient relationships. Moreover, while all of incidences causing complaints were occurred in hospitals. Base on the assumption that these problems could have been early managed if there is a mechanism in the hospital in order to recognize their problems. Therefore, the Consumer Service Centers were set up in 94 public hospitals in 2008 and expanded to cover 363 hospitals in 2011. Method Data collected from all 363 hospitals that have Consumer Service Center in the hospitals were analyzed using descriptive statistics to evaluate the outcome of the model. Results The complaints to the NHSO regarding to the hospitals where the model existed were significantly decreased from 1,266 complaints in 2008 to 720 complaints or 43.12% reduction in 2013. The hospitals have implemented many projects in order to moderate or to solve those complaints at the frontline or at OPD. Furthermore, a surveillance system environment project in 290 hospitals (80%), consumer right information projects in 290 hospitals (80%), shortening waiting time project in 254 hospitals (70%), edutainment project by health volunteers in 254 hospitals (70%), and health service improvement projects in 181 hospitals (50%) Conclusion & Recommendation: Having a Consumer Service Center in a hospital can be a good channel to provide information and consultation, as well as problem solving for the patients. Problems can be solved early or soon enough so that serious consequence can be controlled. As a result, the patients will receive better services quality.
The value of client satisfaction in evaluating the quality of services in a district reference primary health care facility in rural Northern Mozambique

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ABSTRACT

Introduction Patient satisfaction is a major indicator for health-care service quality. We used a triangulation method to evaluate the service quality of a primary health-care referral centre (HC) located in the district of Ancuabe, province of Cabo Delgado, Mozambique. Method/Approach A 5-day cross-sectional study followed clients that sought help at the outpatient consultation during their entire stay in the HC in December 2010. Through 19 trained interview-staff of both genders 3 main outcomes were assessed: reported patient satisfaction (questionnaire); duration of consultations (stop watch); performance of physical examination (observed clinical practice; temperature, pulse, BP and/or mouth examination, tests). The number of health staff attending consultations was also assessed as context variable. Results 404 clients (58% women) with mean age of 30 years (SD 9.45, range 14-55), of whom 27.1% had no formal education, gave informed consent for participation. 91.4% of the clients were ‘satisfied’ or ‘very satisfied’ with the services received. The mean duration of an outpatient consultation was 2.8 minutes (SD=3.9; N=314) while mean service time at the pharmacy and laboratory was 2.3 minutes (SD=2.9; N=225) and 3.8 minutes (SD=6.4; N=61), respectively. 25.5% of the clients received at least one standard physical examination or test during the outpatient consultation independent of their gender. Receiving a physical examination or/and test during consultation increased the probability of reported satisfaction (OR=3.1 [0.9, 1.04]). During 5 days, only one staff attended a mean of 74 outpatient consultations per day (SD=22.7, N=364). Conclusion The time spent during consultations is insufficient to provide a minimum quality of care, however, this did not translate into dissatisfaction of attended clients. In this setting, patient satisfaction is therefore not a full reflection of quality of care. The observed poor quality of care is clearly undermined by the human resource for health challenge and patient management in this setting.
Tackling the tensions in evaluating capacity strengthening for health research systems in low and middle income countries

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ABSTRACT

Background Strengthening research capacity in LMICs is an effective way of advancing health and development but the complexity and heterogeneity of health research capacity strengthening (RCS) initiatives makes it difficult to evaluate their effectiveness. Our cutting-edge study aimed to support people-centred evaluation by enhancing understanding about stakeholders difficulties and recommending ways to make systems for RCS more effective. Methods Through discussions and surveys of health RCS funders, including the ESSENCE on Health Research initiative, we identified themes that were important to health RCS funders and used these to guide a systematic analysis of their evaluation reports. Eighteen reports, produced between 2000 and 2013, representing 12 evaluations, were purposefully selected from 54 reports provided by the funders to provide maximum variety. Text from the reports was extracted independently by two authors against a pre-designed framework. Information about the health RCS approaches, tensions and suggested solutions, were re-constructed into a narrative. Throughout the process contacts in the health RCS funder agencies were involved in helping us to maintain a people-centred focus and to validate and interpret our results. Results The focus of the health RCS evaluations ranged from individuals and institutions to national, regional and global levels. Our analysis identified tensions around how much stakeholders should participate in an evaluation, the appropriate balance between measuring and learning, and between a focus on short-term processes versus longer-term impact and sustainability. Suggested solutions to these tensions included early and ongoing stakeholder engagement in planning, modelling and evaluating health RCS, and rapid assimilation of lessons learned for continuous improvement of decision-making and programming. Conclusions Novel strategies incorporating developmental approaches could improve health RCS evaluations by addressing common tensions and promoting sustainability. Sharing learning about how to do robust, responsive and useful health RCS evaluations should happen alongside, not after, health RCS efforts.
Area Health Research Fellowship (AHRF):
An innovative national program to strengthen
Local Health Systems Research in developing country

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ABSTRACT

Purpose: Health Systems Research Institute (HSRI), Ministry of Public Health (MoH), and Faculty of Medicine, Chulalongkorn University 'collaboratively' launched the Area Health Research Fellowship in Thailand. This paper shares Thailand experience in applying integrated strategies to promote local health systems research. Content: The program comprises three phases. Of 122 applicants from all 12 regions of Thailand, 88 with good purpose statements were selected to participate in 5-day workshops of Phase I in December 2013. Participants were asked to develop 'concept note' using standardized template. Key aspects of research design and specific MoH's strategies/indicators were stated as complete as possible. All templates were synthesized to tailor subsequent sessions to concur with participants' competency. For example, as majority of the concept note contained categorical variables, session on quantitative analysis therefore focused on Chi-square test rather than other irrelevant statistical techniques. On the last day, participants voluntarily joined the competitive 5-minute presentation using the latest version of concept note. Twenty selected candidates then prepared more detailed research proposal before joining Phase 2 in February 2014. Each was introduced to a 'coaching' team, comprising a mentor and a graduate student, to help finalize the proposal. After reviewed by external peers, the candidates formally became AHRF fellows, entitled to US$4,000 'cash award' along with essential research expenses proposed. Moreover, their names were announced through all administrative levels of MoH. Data collection, analysis, and manuscript preparation are conducted in the fields with regular consultation by the coaching teams in Phase 3. Twenty publishable manuscripts are anticipated as mutual academic achievement of the program. Significance: Four major themes (4Cs) emerged from this program can be applicable to other developing countries: (1) Collaborative development, (2) Concept note as a simple tool, (3) Coaching to ensure efficient process and academic outcome, and (4) Cash award and non-financial incentives.
Implementation research as a collaborative endeavour:
A practical guide

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ABSTRACT

Background: Despite the growing focus on implementation research, there remains substantial debate about how to define implementation research and what methods and approaches should be used in its conduct.

Methods: The Guide was coordinated and co-edited by the Alliance for Health Policy and Systems Research using a consultative process with a broad range of actors in the field of implementation research including decision-makers, front-line workers, and researchers.

Results: IR is an important contribution to improving our understanding of context, assessing performance, informing implementation and facilitating health systems strengthening. Key issues presented in the guide that will be elaborated in the presentation include: - IR as a polyvalent tool. Embedded in the real world, IR is a powerful tool for capturing and analysing information in real time, allowing for the assessment of performance and for facilitating scale up. - IR as a collaborative endeavour. IR is often most useful when implementers have played a part in the identification, design and conduct phases of the research undertaken. - IR as a broad research spectrum. IR often focuses on the strategies needed to deliver or implement new ‘implementation interventions’, a definition used to distinguish them from ‘clinical interventions.’ - Aligning IR with need. Implementation research should be demand driven and implementers should play a leading role in defining the questions that are studied.

Discussion and Conclusions: To enhance the way that implementation research is carried out, support is needed in the following areas: 1) Implementation research should be made a core part of programme implementation and used as a tool to improve implementation processes, 2) More funding available needs to be available for implementation research, but just as importantly, this funding needs to align with funding for programmes, 3) Implementation research capacity needs to be boosted by increasing implementation research training opportunities for implementers.
Participatory Health System Research (PHSR): A novel strategy of multilevel capacity development for people-centred Health Systems Research in South Sudan

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ABSTRACT

Background: The ability to participate is usually assumed in participatory research. But there is often the need to develop this capacity to participate in a genuine dialogue and to enable actors to engage in action towards people-centred health systems. Methods: Fourteen women from Renk County in South Sudan were engaged in Participatory Ethnographic Evaluation Research (PEER) to develop their capacity to design research instruments, conduct interviews, collect narratives and stories, and analyse data to identify, prioritize and address their maternal health concerns. Within a year, 10 of them were able to lead work on ‘Innovative Participatory Health Education (IPHE)’ with NGOs employees and theatrical band members. They developed action messages, created health education materials, and delivered them to their community in the form of pictograms, songs, and drama. Parallel to PEER, 10 senior officers in Ministry of Health were engaged in capacity development workshop on Reproductive Health Project Management (RHPM). They used the maternal health issues generated by PEER to develop project proposals on reproductive health. At the end, the local people and senior officers came together to discuss maternal health issues, where senior officers presented their proposals to the community members who gave them feedback and comments. Results: Women believed that PEER enhanced their credibility when they returned to their social circles people were more accepting of what they said. They are more confident about their ability to influence change. Senior officers acknowledged that the process helped them to identify maternal health issues through the eyes of the community and that this knowledge will influence their future decision making. Conclusion: PHSR developed capacities at multilevel, empowered communities with research capabilities, engaged them in identifying and addressing their own health concerns, facilitated knowledge brokering, engage health system actors in identifying and acting on opportunities for people-centred health system strengthening
The operational research assistance project
“A novel capacity development initiative in South Africa' 

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ABSTRACT

Background The report 'Research for Universal Health Coverage' argues that universal health coverage cannot be achieved without the evidence provided by scientific research. Operational research (OR) can provide an understanding of why programmes do not work and guide optimal implementation. However, the limited resources and capacity to undertake OR and translation of evidence into health system improvement present challenges. A capacity development initiative was implemented to undertake OR as an integral component of health programmes to improve the quality and performance of the health system in South Africa.

Methods The project was implemented in collaboration with the Department of Health from 2010 to 2014. Health service providers from all provinces were teamed with researchers from academic institutions and participated in an experiential learning process that developed their capacity to conduct OR. Teams were mentored throughout the process of developing and implementing ethically approved OR studies to address priority programme gaps identified by health services. Results A total of 103 health service providers and researchers participated and 36 studies were undertaken. Findings were disseminated through 32 conference presentations, 8 manuscripts were published in peer reviewed journals and 17 are currently in draft format. Total cost for the initiative including workshops, mentoring, project implementation, data management and analysis, results dissemination at conferences and publication was USD2,534,323. An external evaluation highlighted the capacity development benefit to participants. Despite studies producing actionable evidence, no changes have been implemented in health services as yet. Discussion and Conclusion Advantages of this model included capacity development and addressing gaps through health services driven OR. The cycle to publication of OR findings took longer than expected. The timing and responsibility for knowledge translation activities and sustainability of the initiative need to be addressed.
Improving the governance of health research in developing country: A collaborative and integrative approach for priority setting of national health service research in Thailand

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ABSTRACT

In many low and middle income countries policy makers and health care managers do not have access to timely evidence and knowledge for decision making. Research systems in health in many countries are either underdeveloped or fragmented, with inadequate link to the needs of the health care system. In Thailand, a research center (TRC-HS) was recently established to fill the knowledge gaps to support policy in health care services. One of its first tasks is to develop a national strategy on health services research that includes prioritization of research topics. A collaborative and integrative approach has been used by TRC-HS and it involves extensive review and analysis of the health care system and its context and a serie of consultative meetings with 80 key stakeholders from patient groups, health care providers (public and private), health insurance and financing agencies, and regulators. The strengths, weaknesses, and opportunities and threats were identified and key drivers for short and long term success were discussed. Research themes and topics for health service development were then prioritized based on two main criteria on expected benefits in addressing knowledge gaps and the feasibility of the research. Six key research themes were selected as priority research areas in the next 5 years namely governance and management of health care system for continuity and efficiency at the regional level, system development and model of services for chronic care, implications and preparation for medical hub policy, potential application of innovative health technology for health service improvement, governance of public hospitals, and planning, management, and development of human resource for health services. In addition, the national strategy proposes a number of key interventions to strengthen health service research in Thailand including capacity building of researchers, financing and supporting systems to facilitate health service research, access and management of databases, etc.
Knowing and doing: Developing capacity at multiple levels to increase consumption and production of research in rural Rwanda

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ABSTRACT

Purpose: The 2013 WHO Report advocates for increased capacity to produce/consume research to improve health system effectiveness in LMICs. To date, documented research capacity building (RCB) approaches in LMICs focus on tangible competencies, primarily aiming to produce specific research products. We have deployed a holistic approach to RCB in three rural Rwandan districts. Focus/Content: Led by Partners In Health/Rwanda Research Department, activities have been initiated and guided by the following principles: 1) provide a variety of opportunities for individuals at different stages (novice to experienced) with a clear professional development path; 2) use trainings to strengthen our relationships/collaborations with partners, particularly the Ministry of Health; and 3) when appropriate, have deliverable-driven trainings to reinforce concepts in a mentored environment. From September 2012, a ten-session introductory seminar was held at each district to encourage reading/discussion of research and improve fundamentals in research concepts. Sixty-one individuals successfully completed the training with the median number of articles read per month increasing from one at baseline to four at 12-months (p<0.001). Of these, nine individuals with self-identified projects enrolled into an intermediate operational research training, and all are in data collection stages. Twenty-one statisticians (mapped to six papers) have been trained in survey/DHS analysis and four papers have been submitted. Five students receive funding for a research-based MPhil program, of which one has graduated. Significance: Comprehensive RCB programs must extend beyond skill-specific trainings. Introductory trainings are important to improve incorporating research findings into practice and identify promising researchers to funnel into more advanced trainings. Opportunities for formal public health training are critical for developing site-based research leadership. RCB programs must be developed in parallel with infrastructure and opportunities to participate in research projects. Challenges for consideration include availability of site-based mentorship, flexible training programs accommodating competing work demands, inclusion of women, and funding.
Investing in People: Mozambique's approach to developing a health financing strategy

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ABSTRACT

Purpose: A health financing strategy sets forth a country's vision in developing sustainable health financing mechanisms with implications for years to come. However, implementation and country ownership are often hampered by a lack of capacity to carry out the reform. Mozambique is in the process of developing the country's first health financing strategy. The short-term objective of the health financing strategy is to address the 2.7 billion USD financing gap. The long-term objective is to design a financing system that ensures universal coverage of essential health services, and reduces the risk of catastrophic health expenditure. In this presentation, we describe Mozambique's efforts to reform the financing system through upfront investments in human resources and capacity development. Realising that critical decisions determining the financing systems performance are made by people across various parts of the system, the Ministry embarks on a comprehensive capacity development plan that includes: - Mentorship and coaching of senior leaders at the Ministry of Health and Ministry of Finance; - Targeted skills development at the managerial level to enable directors and managers to guide the financing reform; and, - Technical skills improvement among students and staff to improve analytic capacities. Method: Using a case study approach, the presentation describes our conceptual framework in strengthening the country's capacity, draws on examples from other countries, presents progress (as well as challenges) in Mozambique, and presents a return to investment analysis on the health financing capacity development plan. Significance: Taking a holistic approach to developing a health financing strategy is critical to move towards universal health coverage. Similar to many developing countries, Mozambique's capacity in health financing research and program implementation is low. To ensure country ownership of the reform process, investment in human capital needs to be a central part of the strategy development process.
KEYSTONE: Building the health policy & systems research community in India

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5 Indian Institute of Health Management Research
6 Indian Institute of Technology Madras
7 Indian Institute of Public Health Gandhinagar
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9 Alliance for Health Policy & Systems Research, Switzerland

ABSTRACT

KEYSTONE is a national training initiative to develop new capacities, and channelize latent capacities in multiple disciplines, towards addressing critical needs of health systems and policy development in India. A collective endeavour of several Indian research organizations, KEYSTONE is convened by the Public Health Foundation of India in its role as a Nodal Institute of the Alliance for Health Policy & Systems Research, WHO. This presentation will outline the contents of KEYSTONE, describe early experiences of implementing the initiative, present plans for scale-up, and draw wider lessons for HPSR capacity-building initiatives globally. The production of systematic policy-relevant knowledge for health systems change in India is not adequate to meet country needs. This is attributable partly to inadequacies in numbers of rigorously trained HPSR researchers, since few institutions undertake HPSR training, and partly to a fragmented environment for HPSR. Skilled researchers exist across diverse organizations, but tend to operate within academic disciplinary silos (economics, political science, anthropology, public health), rather than as part of a cohesive change-creating HPSR community. KEYSTONE aims to address this situation by: - Building individual HPSR capacity through rigorous short course training in current HPSR frameworks and methodologies - Cross-disciplinary engagement with researchers, health systems actors, and other learning networks, in teaching and learning HPSR - Active dialogue with health system decision-makers and community-based organizations to ground the development of the HPSR field in real-world priorities - Building organizational HPSR capacity by supporting partner organizations and alumni in replicating the short course in different settings The ultimate goal of KEYSTONE is to activate a nationwide community of HPSR researchers, contributing to enhanced production of relevant knowledge to meet country needs. Our target audience will primarily be those involved with implementing, supporting and participating in HPSR teaching and learning programmes and networks in LMIC contexts.
Expanding human capacity in obstetrics and gynecology in sub-Saharan Africa: Building academic partnerships to reduce maternal mortality

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ABSTRACT

Human Capacity in Obstetrics and Gynecology (OBGYN) in many sub-Saharan African (SSA) countries does not match that required to reduce maternal and neonatal morbidity and mortality, or solve critical reproductive and women's health care problems. OBGYN faculty numbers are inadequate to teach medical students, perform research, conduct surgery, and care for the most complicated pregnancies. The capacity to train new physicians is limited by the lack of faculty OBGYNs to operate a functioning academic department. Inputs from experienced OBGYNs who have created and led viable departments are required for change. A people-centered approach to increase human capacity in OBGYN was first taken in 1989 when the Ghana Ministry of Health and the Carnegie Foundation founded a program to train Ghanaian physicians to become OBGYNs. Expert OBGYN faculty from Ghana, Great Britain, and the United States jumpstarted departments which have produced over 140 West African or Ghana College certified OBGYNs. Ninety five percent have remained in Ghana to teach, practice and provide leadership in the health system and community. This approach was highlighted at a meeting in February 2014 in Accra, Ghana where OBGYNs from 14 SSA countries, governmental representatives and OBGYNs from high-income countries evaluated the key components of an effective academic OBGYN department including: Authentic Partnership, Infrastructure, Curriculum Development, Faculty Development, Community & Midwifery Outreach, Research Monitoring and Evaluation, and Specialty Certification. A global consortium of academic OBGYN departments formed as well as a council of professional societies and specialty organizations to provide training and curricular support. Training African physicians to become OBGYNs and measuring the impacts of deployment into the health system provides a people-centered approach that would improve health outcomes for women at all levels of care. The infrastructure strengthens locally relevant health research to inform policy, advocacy and health system strengthening efforts nationally, regionally, and globally.
Assessing national organizational capacity for health policy & systems research in India: results of a survey

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ABSTRACT

The Implementation Research Platform and Alliance for Health Policy & Systems Research have established Nodal Institutes in countries and regions with a critical mass of institutions engaged in health policy & systems research (HPSR). A crucial objective of the Nodal Institutes is to support the development of HPSR capacity. However, there is limited knowledge about the organizations conducting HPSR in many of these settings, and their current capacities - knowledge that is essential to design capacity building initiatives. The Nodal Institute for India - the Public Health Foundation of India (PHFI), collaborated with the Health Systems Research India Initiative (HSRII) to conduct a survey with the objective of connecting with organizations engaged in HPSR in India and identifying their current priorities, capacities, activities, partnerships, capacity building needs and challenges related to HPSR. The survey is being implemented at the time of the deadline for abstracts, and full results will be available in time for the Global HSR Symposium. The survey was emailed to 43 Indian organizations, identified as those represented in recent editions (since 2010) of Global and Asian Health Systems Research conferences. Additionally, an open call was issued through the HSRII list-serve (1068 members). Quantitative data will be collated, and frequency tables prepared. Qualitative data will be thematically analyzed and organized. Results will include data on the broad areas and specific topics in which HPSR is conducted, the disciplinary competencies (social and health sciences) of organizations channelized towards HPSR, organizations’ prior engagement in HPSR capacity building initiatives, their HPSR capacity building needs, and challenges faced in conducting HPSR. The results will be utilized by the Nodal Institute, in the development of HPSR capacity strengthening strategies and measures. Our target audience are primarily those involved with implementing, supporting and participating in HPSR teaching and learning programmes and networks in LMIC contexts.
Demand-Driven Evaluations for Decisions (3DE):
A collaborative research model to inform national health policy decisions and improve health outcomes in Zambia and Uganda

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ABSTRACT

Purpose: The gap between research and health policy, particularly in low-resource settings, means that research findings often fail to lead to policy change at the local level or health policy decisions are made in the absence of evidence. The 3DE model aims to address the main barriers to the use of evidence by health policy makers in developing countries by conducting rapid, rigorous evaluations by national Ministries of Health (MOH) and using results to catalyse national program or policy changes. Approach: The 3DE model is comprised of three components: 1) Collaboration with Ministries of Health to identify high priority questions that will influence decisions and drive transformational change 2) Design and conduct evaluations with continual input from the MOH and other key stakeholders to generate evidence relevant to national program or policy decisions 3) Engagement of government officials and partners to encourage the use of evidence to inform decisions that affect national health policy and practice. To date, one evaluation has been completed, and three evaluations are ongoing. Based on this pilot, we will present lessons learned about the three 3DE components listed above. Significance: 3DE introduces an innovative model to bridge the gap between evaluation research and the implementation of health policy. In addition to generating rigorous evidence on select topics, this model aims to increase MOH demand for and capacity to utilize timely and relevant evidence. By improving the quality of evidence upon which health decisions are made, resources can be invested more efficiently in programs and policies that work, thereby improving health outcomes.
Strengthening health systems through developing capacity for HRH leadership and governance: Experience of developing an African platform for teaching in health workforce development

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ABSTRACT

Background Availability of adequate and competent health workers is recognized as critical if a health system is to be ‘responsive to the needs, preferences, and expectations of people accessing health services.’ However, about two-thirds of countries in Africa are experiencing acute shortage of health workers, which partly is attributed to the lack of capacity for HRH leadership and governance. Underlying these conditions is another crisis, the poor capacity of training institutions and the lack of training program on leadership and governance in the region. It was against this background that four universities from four African countries (South Africa, Mozambique, Rwanda and Ethiopia) forged an alliance ‘to develop a sustainable masters level educational programme with a focus on Health Workforce Development’. This presentation will reflect on the experience of this collaboration, how and why the intervention is mediated by complex interactions of multiple actors and conditions. Method Theory-driven evaluation, a holistic evaluation approach, is adopted to guide systematic assessment of the intervention. A case study research design is adopted. Data is collected using interviews with key informants, direct and participant observations, and document reviews. Data is analyzed using thematic analysis. Results The collaboration among institutions materialized through engagement over a range of interrelated activities (training in a specialized public health masters degree program in health workforce development, teaching material development, supervision and mentorship) that facilitated the transfer of resources and expertise, and building of collective capacity to develop a regional platform for teaching in the area. Discussion and conclusion This paper emphasizes the need for long-term strategies and engagement, more investment and attention, and concerted and innovative approaches to develop capacity for HRH leadership and governance. The study draws attention to the significance of health workforce development to make health systems more responsive and accessible.
Efficiency of health services at primary and secondary health care level in four departments in Haiti

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ABSTRACT

Background In Haiti, despite improvements in utilization of maternal and child health services thanks to Performance Based Financing (Zeng -2012), service coverage remains weak among lower wealth quintiles (DHS-2012). Currently, donor support constitutes 86% of national health spending (2010-11, NHA). This is expected to decline in future. Improvements in efficiency of health services are imperative for achieving higher returns on health investments. Method 2011-2012 data was collected on operational costs and service indicators from 48 health facilities in 4 departments: North-East, Centre, North-West and the West using a 2 stage probability sampling. Facility type include health center with bed (CAL), without bed (CSL), dispensary and community reference hospital (HCR). A weight of 70% was assigned to patients in CAL. The cost per weighted visit was estimated as a measurement of efficiency of health facility. ANOVA was used to measure efficiency by facility type, ownership and department. Results CALs have a higher cost per weighted visit ($10) than CSLs ($7) and dispensaries ($5). Cost per weighted visit is higher in public facilities ($8) than in private ones ($6). The North-West department produced higher cost per weighted visit ($13) than the 3 other departments ($8 for North-East; $6 for Centre and $3 for the West). At hospital level, North-West has lower cost per bed day ($31) than the 2 hospitals in North-East ($32) and Centre ($43). Although most differences are statistically insignificant, the results point to the wide variation of the cost for service delivery in Haiti. Discussion/conclusion There are wide variations in cost per visit by facility type and ownership, indicating room for further improvement of service delivery. Facilities in the West are more efficient than in other departments because of higher utilization. Further analysis using Data Envelopment Analysis (DEA) method will be conducted to gain better understanding of efficiency.
Players and processes behind the national health insurance scheme: a case study of Uganda.

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ABSTRACT

Background: Uganda is the last East African country to adopt a National Health Insurance Scheme (NHIS). To lessen the inequitable burden of healthcare spending, health financing reform has focused on the establishment of national health insurance scheme. The objective of this research is to depict how stakeholders and their power and interests have shaped the process of agenda setting and policy formulation for Uganda's proposed NHIS. Methods: This is a single case study of agenda setting and policy formulation related to the NHIS in Uganda. It involves an analysis of the real-life context, the content of proposals, the process, and a retrospective stakeholder analysis in terms of policy development. Data collection comprised a literature review of published documents, technical reports, policy briefs, and memos obtained from Uganda's Ministry of Health and other unpublished sources. Formal discussions were held with ministry staff involved in the design of the scheme and some members of the task force to obtain clarification, verify events, and gain additional information. Results: The process of developing the NHIS has been an incremental one, characterised by small-scale, gradual changes and repeated adjustments through various stakeholder engagements during the three phases of development: from 1995 to 1999; 2000 to 2005; and 2006 to 2011. Despite political will in the government, progress with the NHIS has been slow, and it has yet to be implemented. Stakeholders played an important role in influencing the pace of the development process and the design of the scheme. Conclusions: This study underscores the importance of stakeholder analysis in major health reforms. Early use of stakeholder analysis combined with an ongoing review and revision of NHIS policy proposals during stakeholder discussions would be an effective strategy for avoiding potential pitfalls and obstacles in policy implementation. This paper reviews the experiences of two countries with similar stakeholder dynamics. Keywords: Health insurance, Stakeholder analysis, Context analysis, Policy reform, Health financing, Case study, Uganda
Funding Kenyan health centres: experiences of implementing direct facility financing and local budget management

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ABSTRACT

Background The Health Sector Services Fund (HSSF) is an innovative scheme established by the Kenyan Government to disburse funds directly to health facilities. HSSF empowers local communities by making the local Health Facility Management Committees (HFMCs) responsible for planning, budgeting and implementation of HSSF activities. HSSF was implemented nationwide from 2010. We investigated implementation and experience with HSSF in health centres to explore the successes and challenges to date.

Methods We drew on primary qualitative data, complemented by secondary quantitative data from independent fiduciary reports. For the qualitative data collection five districts (2 rural, 2 urban and one mixed), and 2 health centres within each district (total n=10), were purposively selected. Interviews were held with facility in-charges, HFMC members, and users (n=10, 31 and 99 respectively), and with health managers in each district, and 9 national level key informants. Facility income and expenditure documents were reviewed.

Results Overall, HSSF has been implemented successfully in health centres, with funds reaching facilities and being appropriately overseen by HFMCs. There is a general positive impression of HSSF impacts in terms of facility operations, quality of care and staff motivation, patient satisfaction, outreach activities, and utilisation. However, there were a number of unintended outcomes, including: complex and centralised accounting processes; inability to use user fees as easily and as flexibly as in the past; and bypassing of existing management structures at the district level.

Discussion Kenya has recently removed user fees in health centres and dispensaries, increasing the importance of identifying alternative finance sources at this level. The HSSF approach has the potential to fill the gap created by lost user fee revenue in Kenya and elsewhere, while encouraging community participation. However, careful design is required to ensure that reporting requirements are not burdensome and that the mechanism strengthens existing management relationships.
Costs of vaccine programs across 94 low- and middle-income countries

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ABSTRACT

BACKGROUND: While new mechanisms such as advance market commitments and co-financing policies of the GAVI Alliance are allowing poor countries to gain access to vaccines faster than ever, understanding the full scope of vaccine program costs is needed to ensure adequate resource mobilization. This costing analysis examines the vaccine costs, supply chain costs, and service delivery costs of immunization programs for routine immunization and for supplemental immunization activities (SIAs) for vaccines related to 18 antigens in 94 countries across the decade 2011-2020. METHODS: Vaccine costs were calculated using GAVI price assumptions for GAVI-eligible countries, and assumptions from PAHO Revolving Fund and UNICEF for middle-income countries not supported by the GAVI Alliance. Vaccine introductions and coverage levels were projected based on GAVI’s Adjusted Demand Forecast. Supply chain costs were projected using a mechanistic model developed by the HERMES modeling team to determine costs of transport, storage, and labor related to the supply chain. Service delivery costs were abstracted from comprehensive multi-year plans for GAVI-eligible countries and regression analysis was conducted to extrapolate costs to additional countries. RESULTS: Results indicate that the delivery of the full vaccination program across 94 countries would cost a total of $53 billion ($38 billion excluding shared costs) over the decade, including $44 billion for routine immunization and $9 billion for SIAs. More than half of these costs stem from service delivery at $29 billion—with an additional $21 billion in vaccine costs and $3 billion in supply chain costs. CONCLUSIONS: This project builds on previous costing analyses carried out for the Global Vaccine Action Plan and overcomes key limitations by providing an updatable model with scenario analyses. The analysis adds to the current knowledge of the costs of vaccine programs and can support estimations of the funding gap for vaccines to be used by global decision-makers.
Evaluating the impact of national health insurance programme 'Rashtriya Swasthya Bima Yojana' in India

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ABSTRACT

National Health Insurance Scheme of India called Rashtriya Swasthya Bima Yojana (RSBY) was launched in 2008 for poor households in India. Instead of traditional supply side financing, with this scheme Government is moving towards demand side financing for health care. RSBY presently covers more than 110 million individuals in India. In order to measure impact of RSBY, a longitudinal panel research is being undertaken across 8 States of India for a period of three years with six monthly data collection. Since reducing out of pocket expenditure on hospitalisation is one of the most important objective of the scheme it is studied closely in this paper. Results shows that more than 40% of families had to spend from out of pocket on consultation, diagnostic tests or medicines. Overall, the average hospitalization expenditure among RSBY enrollees was INR 4818 while among the RSBY non enrollees, it was INR 9422. RSBY impacted health seeking behavior also and data shows that amongst RSBY beneficiaries 66 percent accessed private hospital while this figure is 29 percent of the RSBY non enrollees. This shows that access to private health care providers has increased significantly for poor families. The paper concludes that though RSBY has been able to decrease out of pocket expenditure on health, it has only been able to do partly and people still have to pay out of pocket. On the one hand this is related to the effectiveness of the implementation of the scheme and on the other hand it also raises the question about the benefit package of such schemes which needs to be more comprehensive than providing a limited cover. Many other developing countries that are planning to move towards demand side financing needs to take a close look at the impact before taking the decision and designing the scheme.
**Strengthening financial management systems and skills to improve district health services in a rural and urban district in KwaZulu-Natal, South Africa.**

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**ABSTRACT**

Background South Africa has implemented a district health system with the aim of delivering accessible, equitable, efficient and sustainable health services. However, districts lack a comprehensive and strategic approach to financial management; have inadequate organisational processes for managing finances, face a shortage of technical skills, and there is often insufficient oversight from facility managers. MatCH (Maternal, Adolescent and Child Health), has a PEPFAR-funded health systems strengthening project in two districts in KwaZulu-Natal focusing on the 6 WHO building blocks. MatCH has contracted a specialist financial partner to build financial capacity at district and facility level. Methods Diagnostic assessments were conducted at 2 hospitals, 1 community health centre and in one district health office between March and December 2013. The assessment covered an analysis of financial systems and processes including adherence to legislation, policy, and the use of generally accepted accounting practices. A standardised tool was used to collect data and included interviews with managers and staff; and document reviews. Capacity building and mentoring was provided based on needs identified. Findings were used to develop a simple toolkit. Results The diagnostic assessments identified key challenges such as an understaffed finance team, no segregated financial management policy, no standard operating procedure manual, inappropriate budget processes, unskilled and inexperienced staff, inappropriate cash flow reporting, and failure to meet reporting deadlines. As a result of the assessments, turnaround strategies were developed collaboratively, including capacity building and mentoring plans. A toolkit was developed for implementation across the province and is being rolled out in 2 districts. Conclusion The use of a standard toolkit with simple checklists and audit tools will assist facility and district health managers to improve financial management and oversight of financial activities. Working with the provincial government ensures the tools are standardised, and using a collaborative approach builds sustainability and local ownership.
Determinants of community-based health insurance coverage in low and middle-income countries: a systematic review

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ABSTRACT

Background: Most low and middle-income countries (LMICs) have been unable to achieve the key objective of universal coverage which is - universal financial protection and access to needed health services. A promising avenue to provide health insurance for the informal sector and the rural populace in LMICs is community-based health insurance (CBHI). This thesis systematically assessed and synthesized factors associated with CBHI enrollment in LMICs. Methods: PubMed, Scopus, ERIC, PsychInfo, Africa-Wide Information, Academic Search Premier, Business Source Premier, WHOLIS, CINAHL, Cochrane Library, conference proceedings, and reference lists were searched for eligible studies available by 31 October 2013; regardless of publication status or language of publication. Both quantitative and qualitative studies were included. Eligible quantitative studies include both intervention and observational studies. Eligible qualitative studies included focus group discussions, direct observations, interviews, case studies and ethnography. Included studies differed significantly in study settings, design, and outcome measures, so the findings are presented in a narrative synthesis. Results: Both quantitative and qualitative studies showed low levels of income and lack of financial resources as major factors affecting enrollment. Also, poor healthcare quality (including drug and medical supply stock-outs, poor healthcare worker attitudes, and long waiting times) leads to low coverage. Trust in both the scheme and caregivers also affect enrollment. In addition, more educated people, men, young people, and larger households were more willing to pay higher for CBHI enrollment. Conclusions: Lack of funds, poor quality of care, and lack of trust are major reasons for the low CBHI coverage in LMICs; and need to be considered when such schemes are set up to ensure financial protection is achieved.
How people-centered is India's National Health Insurance Scheme (RSBY): Lessons from a study on social exclusion in Karnataka, India.

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ABSTRACT

Introduction: The World Health Organisation recommends health systems to be people-centred if Universal Health Coverage (UHC) is to be achieved. Similarly a paradigm shift is needed in social health protection schemes towards becoming people-centred policies. To push for such an approach, is a difficult yet real challenge facing India with a population of 1.2 billion people. In this paper, we review existing literature and our experience on the role of social exclusion in accessing national health insurance scheme (RSBY) in India, to understand how people-centered is it actually. Methods: Our larger study aimed at exploring social exclusion in accessing RSBY via household surveys (n=6040); stakeholder interviews (n=42); group discussions (n=23) in Karnataka, India. These findings along with literature review provided the basis for this paper. We qualitatively subjected them to four action domains of WHO's policy framework for people-centered health care, by adapting it to the scheme design and implementation. Results: Enrolment at doorsteps, cashless hospitalisations and accessibility across states, are few people-friendly designs. However, inequitable access to scheme determined by, socio-political factors and poor information excluded beneficiaries at different levels of implementation. At the service provider level, beneficiaries can choose to access hospitals from either sector. However, inequitable distribution, non-inclusion of outpatient care, insufficient clinical guidelines, and regulation deprives the beneficiary from accessible and appropriate care. Lack of partnership between RSBY and health department does not allow it to synchronize itself with existing health system. Lack of decentralization with a ‘one-size-fits-all’ approach makes insurance the centre of it and not the people. Conclusion: A government health insurance scheme with business model for implementation and social mandate at heart makes it difficult to assess its effectiveness. With India’s move towards UHC considering RSBY a potential platform, there is an urgent need for it to adapt its design and implementation with a people-centred lens.
Bottom-up planning and budgeting to improve primary health care service in decentralized Indonesia: The inclusion of community participations and financing process bottlenecks

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ABSTRACT

Background: Bottom-up planning that includes the community is imperative to improve equitable health care services. In decentralized Indonesia, planning and budgeting for primary health care have even more important roles due to larger power of local government over decision-making and is expected to incorporate local community’s needs. However, planning processes may not have taken up the ideal norms and bottlenecks e.g. funding delays and low budget absorption exist. Objectives: Study objectives were to: (1) analyze the practice of planning and budgeting for primary health care and the community inclusion in planning for health, (2) identify associated bottlenecks in planning and budgeting process, and (3) identify steps to improve the budgeting process. Methods: Bottom-up analysis was used to identify primary health centers planning and budgeting processes in eight disadvantaged districts in East Nusa Tenggara and East Java provinces, Indonesia. Quantitative and qualitative data were collected through health budgeting documents reviews (2011-2013) and individual interviews with primary health center managers, district health office and health planning-related institutions. Results: Although normative planning process stresses the inclusion of people, in practice community often has limited role, planning for primary health care services is also heavily based on decided budget ceiling rather than actual community needs. Bottlenecks in planning, budgeting and disbursement of funds were observed in the study areas, including: misalignment between bottom-up planning and higher political decision-making process; lengthy bureaucratic and administrative processes; limited human resources and capacity; interference from ministries on the standard budget process; and lack of budget disbursement evaluation. Primary health centers experienced late disbursement, where 70-90% of budget realization occurred only in last quarter, hindering the delivery of adequate and quality community health care services. Discussion: In order to ensure adequate health services, planning and budgeting requires more involvement from grass-root level as well as timely improvement that would alleviate health-financing bottlenecks.
Leveraging social health insurance to ensure access of poorest families to primary care services in the Philippines

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Herrera, Rizza Majella
Romero, Daryl
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ABSTRACT

BACKGROUND Consistent with the government's goal of achieving Universal Health Care published in 2010, the Philippine Health Insurance Corporation (PhilHealth) enhanced the Primary Care Benefit (PCB) package in 2012 to enable poor families enrolled to obtain primary preventive services, diagnostic examinations, and drugs and medicines to specified diseases. The primary care providers which are owned by local government units are paid according to the number of enrolled families assigned to them. The payment is calculated annually but the payment is released on quarterly basis. The total amount of payment for PCB is affected by the providers' ability to locate the families assigned to them, perform and update individual health profile and provide the necessary primary care services according to need. This study aims to assess the effectiveness of health insurance payment in promoting access of poor families to PCB, influencing PCB providers' performance and inducing autonomous local governments to allocate resources to sustain primary care services. METHODOLOGY Data were collected from PhilHealth and PCB providers' reports as well as interviews with key informants. RESULTS & DISCUSSION: Between 2010 and 2013, the accredited PCB facilities have increased by 135%. Around 9 million poor families enrolled in PhilHealth were assigned to their primary care providers, about 12.3 M individuals from these families have been located and 10.2 M of them have been seen by their primary care doctor. There is increased health-seeking behavior among poor families and increased case-finding, particularly for non-communicable diseases. Moreover, 89% of the local government units ensured that payments for PCB are retained to health care facilities by establishing a trust fund for this purpose. The implementation of PCB demonstrates that social health insurance can improve access to and enhance the provision of primary care services to address the health needs of the poor families enrolled in PhilHealth.
Impact evaluation of provider payment reform under the new rural cooperative medical scheme in Gansu Province, China

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ABSTRACT

Background: The New Cooperative Medical Scheme (NCMS) which aims to reduce the risk of catastrophic health spending for rural residents has substantially improved health care access and utilization in China. However, cost containment and provider incentive remains a huge challenge, which has been particularly acute in poorer rural areas, such as the North-west. Over the past years, several counties in Gansu province have introduced a variety of provider payment reforms, shifting from the traditional Fee-for-Service to case-based and/or global budget methods, as part of China Rural Health Development Project (Health XI Project) launched at the end of 2008. This study provides the first impact evaluation of these reforms. Methods: Using a quasi-experimental design, we collected NCMS claims data from 2008 to 2013 in three counties. A difference-in-difference analysis is performed to take advantage of the variation in provider payment methods implemented at different years across the counties. We also control for patients’ age, gender, diagnosis and demographic factor of each county in estimating the effects of payment reform on cost (measured by inpatient healthcare expenditure) and quality (measured by readmission rate). In addition to the quantitative analysis, we conduct key informant interviews with policymakers, hospital administrators, and medical professionals to better understand the design and implementation issues involved in the reform process. Results: Preliminary data analysis indicates that in one county, the provider payment reform is associated with 9.8% drop in total health care expenditure per admission. Length of stay fell by 4.9% as a result too. However, other factors such as changes in the demand-side reimbursement rate may also influence the outcomes. Differences in local infrastructure and technical capacity have led to the same payment method implemented differently at the county level. Conclusion: Provider payment reform in rural China can be an effective way to control health expenditure. However, more technical guidance on designing the right payment is needed for future reforms.

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ABSTRACT

Purpose: The Global Vaccine Action Plan highlights the need for immunisation programmes to have sustainable access to predictable funding. Understanding of current and future funding needs, commitments and gaps is required to enhance planning, resource allocation, resource mobilisation and ability to avoid funding bottlenecks, as well as to ensure that co-funding arrangements are appropriate. The aim was to map the resource envelope and flows for immunization in Uganda, between 2009/10 and 2012/13, and to develop a methodology for immunization resource mapping. The study was funded for the first two years by the Gates Foundation as part of a multi-country immunization costing study, and the second two years were funded by IHME and PATH as part of a GAVI Evaluation multi-country study. Methods: The financial mapping developed a customised extension of the System of Health Accounts (SHA) codes to explore immunization financing in detail. Data were collected from government and external sources. The mapping was able to assess financing more comprehensively as hidden health sector costs like human resource for facility and district level were estimated. Results: Over the four years, funding for immunization has been progressively increasing in absolute terms. The Ugandan government contributed up to 55% of routine immunization funds, higher than previously estimated, and managed up to 85% of funds. Immunization service delivery activities used 80% of financial resources. Salaries and vaccines and supplies absorbed most funding. Differences were apparent between actual resource flows and cMYP estimates. Conclusions: Governments and partners need to improve systems to routinely track immunisation financing flows for enhanced accountability, performance and sustainability. The modified SHA coding allowed financing to be mapped to specific immunisation activities, and could be used for standardized, NHA-compatible resource tracking. Recommendations are made for refinement of routine resource mapping.
Can performance-based financing help reaching the poor with maternal and child health services: the experience of rural Rwanda

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ABSTRACT

Background: Since 1994, Rwanda has achieved tremendous progress in health outcomes and use of essential health services. Coverage with most health interventions has dramatically increased among the poor but large disparities remain between socio-economic groups. Methods: We review Rwanda’s capacity to ensure equal access to key health interventions in rural Rwanda where most of the poor live. We focus on Performance Based Financing’s (PBF) potential to improve access to basic services for the rural population and on its interaction with community-based health insurance. Our objective is to find the strategy that will best achieve equitable access to care, making sure that those who are generally left aside, i.e. the poorest, also benefit from greater utilization of services. We used a multivariate analysis with a difference-in-difference model to isolate the impact of PBF on equity in access to care. This is the method recommended for quasi-experimental impact evaluations. We use facilities and time fixed effects and we cluster our analysis at the district and year levels to take into account the evaluation design.

Results: We find that PBF has a positive impact on equitable use of health services when coverage levels are still low. The better off however tend to be the first beneficiaries of increases in utilization if the worse off do not benefit from financial protection, showing an important synergy between PBF and insurance. Finally, in some instance, PBF is not the most effective strategy to reach the worse off.

Recommendations: We recommend that Rwanda sets up demand-side mechanisms for the worse off to support the PBF strategy and that its interaction with other policies is better considered.
Optimizing the performance of health financing systems through a mix of provider payment mechanisms - A case study of Ghana's national health insurance scheme

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ABSTRACT

Background: The health insurance laws in Ghana make for three provider payment mechanisms: fee-for-service, diagnosis-related-groups, and capitation. Although the effects of capitation are known, it was only introduced as a pilot in one region of Ghana (Ashanti Region) in 2012 to test its overall effectiveness in achieving cost containment. The system covered only primary care and accounted for 22% of total claims. This paper examines the pilot after one year.

Methods: A nonequivalent before-after quasi-experimental design was used and control region. Key performance indicators of the NHIS were measured between the two groups on the post-test after adjusting for differences on the pretest, using the reliability-corrected ANCOVA model in the statistical analysis to correct for the bias that would occur as a result of measurement errors. Findings: There was an initial reduction in the number of active subscribers in the pilot region by 20%, compared with control of 27%. There were initial difficulties in assigning subscribers to Preferred Primary Providers leading to patients moving from one provider to the other in search of their PPP. The initial nominal change in claim of -0.3% came to 4.1% after controlling for extraneous factors. Patient satisfaction improved by 20% in the pilot region, compared to only 7% in the control region. Claims submitted by providers reduced by 64.4%. In conclusion, capitation has a potential to reduce the rate of increase in claim cost, improve quality of care and reduce the burden of claim processing. Capitation would however, have to go hand in hand with other payment systems to optimize the provider payment mechanism for health insurance in Ghana.
Evaluation of direct health facility funding initiative in Papua New Guinea

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ABSTRACT

Background: Health centers in Papua New Guinea charge user-fees to recover operational costs. Delays in provision of regular budget allocations result in inadequate funds to maintain operational activities. A Direct Health Facility Funding (DHFF) program was piloted in the Bougainville region to link the direct provision of grants to recipient health centres with a requirement to cease charging user fees. This evaluation study reviewed the effectiveness of the processes and procedures for implementing DHFF after two years of the pilot initiative. Methods: A four phase approach was adopted to achieve the intended objectives of the evaluation. Review of reports; semi-structured interviews; field visits to nine sample DHFF and non-DHFF health centers and exit interviews were conducted in 2013. Results: DHFF implementation arrangements were in place and generally worked well with some limitations. The majority of health centers provided a higher number of services following receipt of DHFF funding. Health workers were more motivated to improve service provision. Service providers and local subdistrict committee members perceived that DHFF had had a positive impact on outreach activities, patient referrals, quality of care and cleanliness. However there was some variation in the extent of capacities for managing fund and providing services across different health centres. All the exit interviewees (n=39) from DHFF Health Centres expressed satisfaction with services. Conclusions: This evaluation identified the requirements for more effective DHFF arrangements: active health committee and community engagement; capacity development for managing DHFF; compliance with guideline; timely disbursement & review of expenditure reports; and strong monitoring arrangements. This study indicates that direct allocation of funding to health centers on time helped to meet increased demand of health services and has the potential to be a complementary policy to support the abolition of user fees.
Challenges and issues of implementing health insurance program in public hospitals: Analysis of Comprehensive Health Insurance Scheme (CHIS) in Kerala, India

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ABSTRACT

The widely quoted reason for the success of Kerala in the field of health is the significant public investment in health through tax based provision of care, mainly through public provisioning. To reduce the burden of catastrophic health expenditure, the Kerala government recently introduced a health insurance scheme to cover the hospitalization expenses of below poverty line population (BPL) called Comprehensive Health Insurance Scheme (CHIS). CHIS aim at providing secondary care to BPL households through a Public-Private Partnership Model. The premium for the poor households is subsidized by the government and the insurance is managed by private health insurance provider and the provision of care is majorly through public hospitals. Objectives and Methodology The main objective of this paper is to looks into the challenges and implementation issues of managing the health insurance scheme by public hospitals in hitherto tax based system of health service delivery. The study used an implementation research framework quantitative and qualitative analysis was used. Claims data from all public hospitals was analyzed to understand the pattern of reimbursement to hospitals. In-depth interviews were done with the hospital managers, insurance provider and government officials to understand the implementation issues and challenges. Discussion & Conclusion The analysis of the claims data revealed that the rejection of claims in public hospitals were around 13 -15 % and this was a major factor concerning the effective implementation of the scheme. Due to this hospitals were incurring considerable loss in insurance reimbursements leading to declining revenue from the scheme. The qualitative analysis found that the lack of knowledge of hospital managers and doctors of public hospitals in insurance administration and absence of systematic documentation of the treatment and patient records as the major factor for rejection of claims in the public hospitals. Improved capacity building and proper training of hospital managers and doctors in insurance administration can improve the implementation of the scheme.
The impact of innovative health financing mechanisms on patient centered care and health outcomes

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ABSTRACT

Background: Innovative health financing interventions can improve access to targeted, patient-centred health care services, improving health outcomes for mothers and children. For this research, innovative financing interventions are defined as the following health programs that use financing to change behavior on either the demand and/or supply side: conditional cash transfer programs, voucher programs, community based health insurance, health equity funds, and pay for performance. While each of these innovative financing interventions have been studied as standalone programs, no research has ever examined their impact looking across countries and over time.

Methods: Panel data are collected for 117 countries over the period 1995-2010 in order to measure the impact of these five innovative health financing interventions on infant, child and maternal mortality. Qualitative methods are used to determine the date of implementation, the size, and estimate the impact on patient-centred care. The results control for traditional government funding for health services, donor funding, GDP, population size, government effectiveness, and initial levels of mortality.

Results: Those countries that invested in more innovative financing interventions had significant declines in infant, under-5, and maternal mortality. The impact in infant and child mortality is highest in low income countries, while the impact on maternal mortality is highest in middle income countries. Other forms of health care financing, including spending on social health insurance and general government health spending, are less effective than these five innovative financing interventions in decreasing infant and maternal mortality.

Conclusion: Innovative health financing programs have the potential to improve health outcomes for vulnerable populations as well as provide quality, patient-centred care. These results demonstrate their positive impact on maternal and child health, controlling for a number of other factors. Additional research is needed to understand further how they can improve patient-centred care.
Political economy of universal health insurance processes in Vietnam

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ABSTRACT

Background: In the last twenty years after the Doi Moi in 1986, Vietnam has achieved good health results similar to those in high and middle-income countries thanks to several new policies to achieve universal health insurance (UHI). Due to the lack of information about the implementation and evaluation, we conducted a study to describe the policy process of health insurance policies from agenda setting to implementation and evaluation. Methods: This is a cross-sectional design and qualitative methods. A total of 54 key informants were involved in in-depth interviews in Ha Noi and Hai Duong province and 420 documents related to UHI (papers, policies, articles, assessments, etc.) were reviewed. Results: Health insurance in Vietnam was introduced in 1992. Since then, several UHI policies were developed. These processes are contingent and persistent to gradually expand target population, benefit package and reducing the financial risk for the users. It is gradually expanding the target groups and has reached the coverage of 64.9% (2011). Policy processes are taking the incremental with 'learning by doing' approach. However, the government lays more emphasis on increasing coverage than service package and financial protection. There was limited involvement of Civil Society Organizations in all policy processes. The policies offer limited financial protection and have high out-of-pocket payment due to escalating costs of services and insufficient provider payment mechanism. Fragmentation of management and limited institutional capacity are also not easily solved. Conclusions: Some lessons learned could be identified. First, Vietnam needs to mobilize the resources in a sustainable and viable ways to support the key target groups. Secondly, the country should take multiple approaches to reach universal coverage, including social health insurance, target subsidies and voluntary health insurance. Thirdly, UHI reform takes time and the most difficult population groups are yet to be covered.
Cross-subsidization of healthcare financing at the hospital level: case studies of selected public hospitals in Thailand

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ABSTRACT

Background: To finance equitable health systems, policymakers must understand provider's incentives, particularly those in responding to different reimbursement policies. This empirical study aims to identify and analyze possible cross-subsidization across health schemes within the public hospitals in Thailand. Methods: This observational study employed a mixed-methods research design. Qualitative data were collected from focus-group interviews of 30 hospital administrators in three selected public hospitals, and content analysis was used to synthesize a mental model of how hospital administrators making decisions related to the concept of cross-subsidization. Quantitative data analysis was used to compliment on the issues of unit-cost difference, difference between charge and cost, and difference between reimbursement and cost across health schemes. Results: Content analysis reveals four emerging themes. First, the concept of cross-subsidization is perceived differently among hospital administrators. Second, payment policies create obstacles to hospitals' financial management. Third, organizational factors also create obstacles to hospitals' financial management. Lastly, hospitals respond to payment policies of health schemes by various measures. These findings are supported by quantitative results, which suggest the unit costs and the differences between reimbursement and cost vary across health schemes after controlled for other patient characteristics. Nonetheless, no evidence suggests that hospitals cost-shift by increasing prices charged to out-of-pocket payment patients to compensate for the loss. Discussions: Despite no direct evidence of cross-subsidization, we found three patterns of decision-making of hospital administrators related to cross-subsidization, including implementing no management practices for cross-subsidy, initiating organizational practices to reduce negative financial impacts, and attempting to negotiate with health schemes on fair reimbursement rates. Therefore, when evaluating the impact of any payment policies, policymakers should consider not only an impact to patients of any particular health scheme, but also an impact to other patients groups within the hospitals, and adjust financing policies to adequately pay for health services provided.
Impact of adjustment of the NCMS reimbursement policies on the maternal health services utilization

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ABSTRACT

Abstract Background The new rural cooperative medical scheme (NCMS) is one of the most important pillars in the health financing reforms in China and it includes a maternal care benefits package which is associated with the increasing of maternal health services. The local compensation policies have been in constant adjustments in recent years. In Yuyao, our study county from Zhejiang province, the deductible in 2011 dropped by 40% than in 2008, and the reimbursement cap line was increased from 30,000 to 80,000. The aim of this study was to reveal the impact of reimbursement policy adjustment on maternal service uses in Zhejiang.

Methods Two cross-sectional studies were performed in Yuyao from 2008 to 2011. Local women who had delivery history in the recent five years were recruited. A self-designed questionnaire was used to collect the information about their delivery history, and their reimbursement status in NCMS. Chi-Square tests were used in the analyses after the data were stratified by income. Results 154 women were enrolled in this study. Half cases were investigated in 2008 and half were in 2011. In 2008, only 9.1% of pregnant women got the reimbursement from NCMS, but the proportion boosted to 36.8% in 2011 (c²=16.70, P<0.001). In the low-income group, the Chi-Square tests revealed some significant changes on services uses between 2008 and 2011, the proportion of postnatal visits rose from 55.3% to 88.55 (c²=6.90, P=0.01), and the proportion of deliveries in secondary and above institutions rose from 25.5% to 73.9% (c²=12.97, P<0.001). There were no significant results in high-income group.

Conclusions Our study finds that financial compensation increasement works in improving maternal health services for low-income population. In the process of health financing reform in China, more tendentious policies should be put forward to protect low-income women in maternal health care in the future.
The impact of health financing policies on household spending in Cambodia

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ABSTRACT

Background After three decades of civil war and first free and fair election in 1993, Cambodia has put substantial effort into health sector reform. User fees, introduced in 1996, were recognised as a barrier to utilisation. A number of policies have subsequently been introduced to reduce financing barriers including Health Equity Funds, Commune Based Health Insurance, Voucher, and Social Health Insurance since the early 2000s. Methods We use the 2004 and 2009 Cambodia Socio-Economic Survey to measure the impact of user fees, health equity fund, and community based health insurance on household health spending. We employ a difference-in-difference model at household level to control for unobserved bias in programs participation resulting from time invariance. A two-part model is used at household level: a probit model estimates the probability that a household will seek treatment; then conditional on a positive outcome, the size of out of pocket payments are estimated by ordinary least-squares (OLS). Results The results suggest that the implementation of health equity funds have helped to increase utilisation of health services and reduce total household spending (p<0.01). People in health equity funds areas are more likely to seek care at health facilities. The health equity funds appear to more than compensate for the effect of user charges so that household out-of-pocket payments for medical treatment are significantly lower for health equity funds areas than before the intervention was implemented while no significant difference is found at user charges areas. Discussion/conclusions User fees have tended to increase spending on health care and place a considerable stress in household budgets. Methods such as health equity funds help to mitigate fees and are important in expanding financial access to health services.
What's in the black box of pay for performance programs? Health facility inputs and institutional deliveries in the Rwandan national program

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ABSTRACT

Background: Various developing country health systems have recently introduced pay-for-performance (P4P) programs, which aim to increase service provision and quality using financial incentives. P4P programs contract directly on outputs without specifying the mechanisms for improvements, allowing providers to innovate and modify different aspects of health care delivery as needed. Characterizing these provider responses can help to identify successful mechanisms for quality improvement and enhance our understanding of the links between P4P and overall health systems strengthening. Methods: In this paper, we examine provider input responses to the Rwandan P4P program using facility-level data from the Demographic and Health Survey Service Provision Assessment collected in 2007 after program implementation. We focus on facility-level incentives for institutional deliveries, which resulted in higher institutional delivery rates. Exploiting the randomized roll-out of the program to identify P4P effects, we compare facility inputs across treatment and control facilities using linear regression. Results: We find significant differences in delivery-specific human resources, process measures, and management but few differences in delivery-specific equipment and supplies. We find significant differences in general facility management but no differences in general human resources or physical inputs. Additionally, we perform a mediation analysis to assess the link between inputs and outcomes and find that the observed input differences explain a relatively small fraction of the P4P effect on institutional delivery rates. Discussion: While these results are consistent with the idea that facilities respond to P4P by increasing the output of contracted services, the small mediation effects indicate the potential importance of unobserved factors, such as effort, in the provider production function. Furthermore, the null results for general inputs suggest a weaker link between P4P and overall health system strengthening.
Differential ceiling on copayment: Does it help to reduce catastrophic payment in South Korea?

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ABSTRACT

Background: South Korean National Health Insurance (NHI) has been characterized as high out-of-pocket (OOP) payment despite universal population coverage. A new policy of differential ceiling on copayment was introduced in 2009, whereby patients were responsible only for paying copayment up to pre-designated thresholds according to their contribution levels. This study aims to examine the effect of differential copayment ceiling on financial protection as well as on utilization of health services. Methods: Using Korea Health Expenditure Panel data (2008-2011), multiple and logistic regression models were generated to investigate the effect of differential ceiling on access to health services and financial protection, respectively. The former was measured as treatment days while the latter as OOP payments exceeding 10% of household income. Among right-hand side variables were interaction terms of the new policy with contribution levels. The regression models were applied to the whole households with NHI beneficiaries (N=6,555) and households with cancer patients (N=505). Results: Disparity in incidence of catastrophic payments among different income groups was evident. Among the whole households, copayment ceiling increased utilization across all income groups, which led to increases in catastrophic payment among the lower 50%, with no varying effect across different income groups. Among the households with cancer patients, copayment ceiling increased utilization among the lower 50% and decreased the probability of catastrophic payment among them, but with no statistical significance. Discussion/conclusions: Differential copayment ceiling contributed to increased use of health services both in all patients and cancer patients. However, it widened the disparity in catastrophic payment among the whole households while it could not reduce catastrophic payment significantly among the households with cancer patients. The effect of differential copayment ceiling on financial protection seemed limited due to relatively high share of uncovered services in the NHI.
Healthcare utilization and expenditure for chronic and acute conditions in Georgia: Does insurance benefit reflect the population's health needs?

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ABSTRACT

Introduction: In 2007 the Georgian government introduced a fully state subsidized Medical Insurance Program for Poor (MIP) with the objective of delivering better financial protection and improved access for the poorest segments of society. Studies evaluating MIP have noted its positive impact on financial protection, but only a marginal impact on improved access. To better assess the effectiveness of the MIP for different conditions, and to identify areas for improvement, we explored whether MIP differently affects utilization and costs among chronic patients compared to those with acute health needs. Methods: Data were collected from two cross-sectional nationally representative household surveys conducted in 2007 and 2010 and looking at health care utilization rates and expenditure. Approximately 3,200 households were interviewed in each wave using a standardized survey questionnaire. Differences in health care utilization and expenditure between chronic and acute patients with and without MIP insurance were evaluated using coarsened exact matching techniques. Results: Among patients with chronic illness, MIP did not affect utilization or expenditure on outpatient drugs, but was associated with a 20 Gel reduction in provider fees. For acute patients MIP was associated with increased odds (OR=1.29) of health service utilization and with reduced costs. As for chronic patients reporting acute complications during the 30-days prior to interview, MIP was associated with reduced odds of self-treatment (OR=0.64) and drug expenditure (27 Gel less). Discussion/Conclusion: Our findings suggest that while the MIP may improve utilization and reduce costs incurred by patients with acute health needs, its benefits for chronic patients was marginal. This suggests that, in its current form, the MIP is not adequately reflecting the needs of the aging Georgian population where chronic illnesses are prevalent. Increasing MIP benefits, particularly for patients with chronic illness, should receive priority attention if universal coverage objectives are to be achieved.
Can internal contracting deliver a system-wide change? A case study of a public health care reform in Cambodia

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ABSTRACT

Introduction: Contracting of service provision has been used to improve the quantity and quality of government health services in many developing countries. Yet, its potential to address constraints at different levels of the health system has been understudied. Using WHO System Thinking framework and the Cambodian reform as a case study, this paper examines the extent to which the institutionalised contracting mechanisms overcame management constraints and sustained improved district health services. Data and methods: As part of a PhD study, this examination employed a mixed-methods approach based on documentary analysis of official and grey literature, key informant interviews with officials working at different levels of the health system and a cross-sectional survey among primary healthcare staff working in contracted districts. Results: The implementation of contracting resulted in an improved sense of accountability and ownership among local managers, addressed critical issues in human resources management (i.e. underperformance of staff, staffing gaps), strengthened financing and provider payment systems and strengthened local management capacity and oversight of health services. Financial incentives from performance contracts added to staff income and improved their job motivation, combined with effective contract management resulted in improved conditions of health facilities and responsiveness of facility services. Official health services data indicated that health districts implementing contracting consistently achieved higher coverage of essential primary care services than health districts that did not implement contracting. Constraints remained, including the incomplete application of contracting, lack of coordination and alignment of human resources and personnel policies, and the insufficient allocation of resources. Conclusions: Internal contracting in Cambodia, despite its relatively limited application, sustained positive changes in the functions of district health system. Its full potential to render a system-wide change depends on the comprehensiveness of contracting application at all relevant points in the system and alignment of relevant policies.
Effects of interventions to raise voluntary enrollment in a social health insurance scheme: A cluster randomized trial

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ABSTRACT

A major challenge facing developing countries towards achieving universal social health insurance coverage is enrolling the informal sector. This study evaluates two sets of interventions aimed at raising enrollment rates among informal sector families in the Philippines' government's Individual-Payer Program (IPP): a mix of information and a 50% subsidy; and a package of measures that reduce the effort a family has to make to enroll. In this cluster randomized trial, 179 out of 243 municipalities were randomly assigned to be intervention sites and 64 as control sites. Across the 243 municipalities, 2,950 households were interviewed in February-March 2011. The IPP-eligible but unenrolled households in the intervention sites were provided with an information kit and a 50% premium subsidy voucher, valid until the end of 2011. Families in the control sites received nothing. In January 2012 the names of families who used their vouchers were identified, and in February 2012 a sub-experiment began with the non-compliers. All were informed that their voucher had been extended, and were re-sent the enrollment kit and SMS reminders. Half were told that the enumerator in the endline interview could help the family complete the enrollment form, submit them to the insurance agency and then mail the insurance ID card to the family. At baseline, a total of 1,124 IPP-eligible families were not enrolled. In the control sites 9.9% of IPP-eligible individuals had enrolled by the end 2011, compared to 14.9% in the intervention sites. In the sub-experiment, the enrollment rate was 3.4% for the control group, but 39.7% among the group receiving additional assistance in completing the form. A partial premium subsidy bundled with information can increase voluntary enrollment in a SHI program, but is less effective than an intervention that reduces the burden that the enrollment process places on families. Even the latter intervention, however, left most of the eligible families unenrolled.
How well are we protected against out of pocket expenditure?  
User's perspective on state funded health insurance scheme in India.

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ABSTRACT

Background To curb impoverishing effects of out of pocket expenditure and enhance access to quality health services Governments in developing countries are adopting 'health insurance as a mechanism to finance health services often with a targeted approach. Government of India started 'Rashtriya Swasthya Bima Yojana' or National Health Insurance Scheme for economically vulnerable households in 2008. RSBY now claims to have covered half of the targeted population, however after implementation of five years evidence indicates poor awareness and uptake of services in the programme. This paper presents qualitative investigation of implementation and narrates 'how' beneficiaries feel about being 'financially protected' through the programme and 'why' some households could not use services in case of need. Methodology We collected data from 16 focus group discussions and 34 in depth interviews of eligible population from five districts of Maharashtra in 2012-13. The transcripts were analysed using a coding framework based on research question and literature using inductive approach. Results The result highlight gaps between expectations of users and programme implementation. Insufficient information about the programme, inability to comprehend structure of health insurance mechanism and distance to the hospital emerge as key reasons for non utilization. Amongst those who reported use incidence of partial out of pocket expenditure are also reported. Conclusion The programme needs to reconsider its features, implementation methods so that user acquire appropriate information and seek hospitalization in case of need. Appropriate decentralization of implementation through use of local governance institutions, induction of monitoring systems are key requirements at the moment. While health systems globally take up 'health insurance' as a mechanism to finance health services there is need to inform users with utmost accuracy.
Out-of-pocket expenditure on chronic non-communicable diseases in Sub-Saharan Africa: The case of rural Malawi

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ABSTRACT

Background In Sub-Saharan Africa (SSA) the disease burden of chronic non-communicable diseases (CNCDs) is rising considerably. Given the weaknesses in existing financial arrangements across SSA, expenditure on CNCDs is often borne directly by patients through out-of-pocket (OOP) payments. This study explored patterns and determinants of OOP expenditure on CNCDs in Malawi, a country which in principle offers basic healthcare services free of charge at point of use. Methods We used data from the first round of a longitudinal household health survey conducted in 2012 on a sample of 1199 households in three rural districts in Malawi. We used a fully digitalized system for data collection and a two-part model to analyze determinants of OOP expenditure on CNCDs. Results 475 respondents reported at least one CNCD. More than 40% of them incurred OOP expenditure. The amount of OOP expenditure on CNCDs comprised 10.1% of monthly disposable income and displayed a regressive pattern, with the poorest households spending 30.3% of monthly disposable income on CNCDs. Higher severity of disease, CNCDs targeted through active screening programs within the framework of the Malawian health system, and use of formal care were significantly associated with an increased likelihood of incurring OOP expenditure on CNCDs. Being female, Aomwe and household head, longer duration of disease, CNCDs targeted through active screening programs, use of formal care, higher socio-economic status, and higher education level of household head were positively associated with the amount of OOP expenditure on CNCDs. Conclusion Our study showed that, in spite of a context where care should in principle be available free, OOP payments for CNCDs are still considerable and impose a considerable financial burden on rural households, especially among the very poor. This suggests the existence of important gaps in financial protection in the current universal coverage policy advanced by the government.
Understanding stakeholders preference in criteria for prioritizing reproductive health interventions in district councils health planning in Tanzania; evidence from discrete choice experiment.

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ABSTRACT

Introduction The aim this study is to explore and measure the individual preference for criteria in prioritizing reproductive health interventions in the context of the district council health planning in Tanzania. Methods We randomly selected three districts councils in Mwanza region. We conducted the study in three groups in the three districts of study: members of the council comprehensive health planning committee, members of the Reproductive and Child Health Section (RCHS) in the district and members from the general population. We used the Discrete Choice Experiment (DCE) approaches to elicit priority setting criteria preferences among the members of the three groups. We undertook statistical analysis using the multinomial probit (MNP) and mixed logit regression to model respondents' choices as a function of the criteria scenarios. Results The results show that the relative importance attached to different criteria in priority setting process differs across the study groups. The general population relatively considers effectiveness of the intervention criteria as important followed by magnitude of the problem. The Reproductive and Child Health Section (RCHS) relatively considers magnitude of the problem, effectiveness, affordability and cultural acceptance respectively as important criteria in prioritizing reproductive health interventions. The district council’s comprehensive health planning committee attaches the relative importance to Responsive to National and International goals criterion followed by affordability, vulnerable groups, and positive social consequences criteria in prioritizing reproductive health interventions. The mixed logit model results show there is variation in criteria preferences among individual within the three groups of study. Conclusion Individual preference on criteria ultimately shapes the decision making about reproductive health intervention option to choose leading to different ordering of interventions in a decision situation. Understanding population preferences in priority setting criteria is important in informing policy maker developing framework to guide the priority setting process.
Financial burden and impoverishment due to cardiovascular medicines in low and middle income countries: an analysis with illustration from India

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ABSTRACT

Background: Medicine costs are said to be a major reason for financial burden in low and middle income countries (LMIC) as they often lack health insurance, more so with the increasing prevalence of non-communicable diseases (NCD). We estimate the effect on poverty of purchasing cardiovascular medicines in India. Methods: We created a treatment ladder of cardiovascular medicines with an Aspirin, Atenolol, Atorvastatin, Losartan and Amlodipine to reflect a step-up therapy approach for cardiovascular diseases. Drug prices were Government of India mandated ceiling prices for essential medicines plus taxes. Daily per-capita expenditures obtained from the latest National Sample Survey were used as a measure of available resource. Poverty thresholds were used as set by the Planning Commission in 2013. We calculated step-wise projected incidence and intensity of impoverishment due to medicine purchase. Findings: Daily cost of medicines at Step 1 was ₹0.13 (₹1=$0.016) with Aspirin 75 mg, in Step 2 it was ₹2.32 with addition of Atenolol 50mg, ₹8.88 in Step 3 with the addition of 10 mg of Atorvastatin, ₹11.53 in Step 4 with Losartan 25 mg and ₹13.77 in Step 5 with addition of Amlodipine 5mg. 22.6% of rural and 14.3% percent of urban Indian population is poor at the designated poverty thresholds. The need to purchase Step 2 medicines would impoverish an additional 5.7% rural and 3.3% urban population; poverty gaps would increase by 0.64% and 0.44% respectively. At step 5 the poverty ratios would increase by 36.0% and 18.3%; poverty gap increase would be 16.7% and 3.2%. Using higher doses of Atenolol, Losartan and Atorvastatin in Step 5 would increase the poverty ratios by 64.9% and 43.1%. Conclusion: Medication costs have the potential to cause impoverishment in a significant proportion of people in India. As cardiovascular disease prevalence increases, such costs are likely to be a major reason for impoverishment.
Increasing access and financial protection: Evaluation of an innovative microinsurance partnership in Lagos, Nigeria

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⁵ Abt Associates HFG project, Nigeria

ABSTRACT

Background: Informal sector workers in Nigeria and elsewhere lack access to quality health care and protection from health care expenses. The DFID-funded PATHS2 project facilitated an innovative partnership between a Lagos microfinance bank and a health insurance company to develop a low-cost health insurance product for microfinance loan clients and their families. The insurance provides access to a basic package of health services including maternal and newborn care at public and private health providers. The USAID-funded Health Finance and Governance (HFG) project is collaborating with PATHS2 to conduct an impact and process evaluation of this microinsurance partnership. Methods: To assess the impact of insurance on health care use and spending, the researchers conducted a baseline survey of ~1,000 microfinance clients in early 2014; an endline survey will be conducted in 2015. Individual interviews are being conducted with a sample of 200 clients to document how the insurance product is being rolled out, review clients' experience with the enrollment process and their use of covered services, assess understanding of the product, and measure satisfaction. Results: Early process evaluation results indicate that information systems linkages between the bank and the insurer require strengthening to ensure rapid processing of enrollment data. Careful training of loan officers is essential to promote clear communication of the costs and benefits of health insurance, a product they have not previously distributed and which is new to many clients. Weekly collection of small premium payments makes the product accessible to this low-income clientele. Discussion: Lessons learned from this evaluation will be used to better reach and meet the needs of low-income individuals. Results will inform the Lagos State Ministry of Health as it considers subsidizing micro health insurance risk pools for low-income populations, and facilitate the potential expansion of the innovative partnership in other states in Nigeria.
Karnataka's roadmap to improved health: cost effective solutions to address priority diseases, reduce poverty and increase economic growth

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ABSTRACT

Background: This paper is based on research and analysis undertaken by the Centre for Global Health Research in collaboration with the Registrar General of India, applying cost-effectiveness methodologies developed by the Disease Control Priorities Project 2 (http://www.dcp-3) to data on causes of death in Karnataka, India. Methods: The study is based on: (i) results of the Million Death Study, which examines deaths in households across the country to assign a probable cause by verbal autopsy; (ii) Cost-Effectiveness Analysis of interventions to identify those that will avert the greatest number of deaths at least cost; (iii) analysis of state health budgets and expenditures; and (iv) health systems analysis of major constraints confronting the system based on semi-structured interviews with Health Department officials at all levels. Results: Based on the analysis of the leading causes of death, the paper suggests an Entitlement Package of cost-effective, scalable interventions that can avert over 145,000 premature deaths in the state at the cost of about Rs. 650 (US$12) per person per year. Currently the bulk of health expenditures are paid for out-of-pocket, causing a heavy financial burden on poor households. In order to reduce regressive and inefficient private out-of-pocket expenditures, government investment in health must increase substantially. Discussion: Government of Karnataka can take several steps to achieve good health at reasonable cost: (i) increase health budgets sufficiently to crowd out private spending for cost-effective services; (ii) re-allocate currently available funds to provide comprehensive coverage for the Entitlement Package; and (iii) put in place a universal health program with a combination of direct government provision through a network of public health facilities and contracted private provision of selected services, paid for by either government or social insurance.
Contracting health services in Cambodia: From external to internal contracting models and its implications

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ABSTRACT

In 2009, Cambodia switched from external contracting to NGO providers of care to internal contracting to government providers, Special Operating Agencies (SOAs), within the public health care system. SOAs aim to change the attitude and behaviour of health providers to provide quality services and to increase utilisation of services. This paper aims to identify the main reasons for change from external to internal contracting, and the consequences for service utilisation and equity, and effects on health service organisation. This paper presents the results from a study in 4 provinces in Cambodia where SOAs operate. 13 key informant interviews at national and provincial levels as well as 24 in-depth interviews with health care providers and managers were conducted. Existing data on antenatal care, deliveries by trained professionals and at health facilities, and child immunization utilisation between 2009 and 2011 were analysed. Several themes emerged from the interviews. (1) Reasons for introducing internal contracting. (2) Health workers and managers understanding of the scheme. (3) How health services are managed: less strict regulations allow staff and managers to leave the health facilities during working hours. (4) Effects of the scheme on performance of the health system: health workers are more punctual arriving at work; services are provided 24 hours per day; many respondents believe that utilisation of services by the poor has increased but this may be attributable to the Health Equity Fund scheme. Health workers and managers had different perceptions of the trends in utilisation since adopting the SOA model. Analysis of the existing secondary data suggests that there is no clear, consistent evidence that SOA districts perform better than non-SOA districts. As external funding for contracting is drying up, SOAs may be one vehicle to enhance ownership, capacity and sustainability for health sector development in Cambodia. However, there remain doubts about their effectiveness.
An impact evaluation of the voluntary student health insurance scheme in Vietnam

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ABSTRACT

Background Vietnam implemented a nationwide Voluntary Student Health Insurance (VSHI) scheme in 1998 with the aim of strengthening the school health system and reducing the level of health inequity among school-aged children. After more than a decade of its implementation, challenges remain in terms of high out-of-pocket (OOP) health spending and low access to health services, especially among rural and poor children. Methods A panel dataset was constructed from a cohort of children from the Young Lives (YL) study in Vietnam. Demographic, health and education information were captured using two household survey rounds conducted in 2006 and in 2009. A difference-in-differences (DID) approach was applied to the panel dataset in order to exhibit that the VSHI scheme is associated with differential improvements on health, learning and household-spending outcomes among primary school students in Vietnam. Results The scheme was estimated to have contributed to improvements in nutrition status among school-aged children, with a 4.7-5.1% increase in their recorded body mass index (BMI). There was also an observed 10-10.8% increase in the probability of a health facility visit. However, the increase in health care utilization translated to an 11.8-14.2% rise in the probability of incurring OOP expenditures for their treatment. Conversely, the scheme is associated with increased household non-health spending for food and non-durable goods. Finally, the results suggest a positive association between VSHI coverage and learning ability, with VSHI-enrolled students scoring 3.712-4.070 points higher on a standardised vocabulary test. Conclusions The results suggest that improving access to a school-based social health insurance program has a positive impact on the health and well being of primary school children in Vietnam. Important policy implications include ensuring continuous coverage and integrating lessons learned from the implementation of the voluntary scheme as the government embarks in its goal to attain universal coverage in Vietnam.
Assessment of rural health purchasing arrangements in China

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ABSTRACT

Background: Strategic purchasing aims at maximizing health system performance and takes the health preference of people as basis to decide which interventions should be purchased, how and from whom they can buy them. At present China, the purchasing arrangements are not perfect and several issues should be resolved urgently. Moreover, the limited research findings have not proposed effective solutions. Therefore this research project is considerably necessary and significant. The objectives of this study is to describe the purchasing arrangements in current China, analyze the factors which block the system performance, and propose what roles are purchasers expected to play in progress towards universal health coverage (UHC) from the perspective of strategic purchasing. Methods: This study applies the model of multiple principal-agent relationship to the examination of relationships among the performers within the new rural cooperative medical scheme (NCMS) in China. We obtain information from case study and qualitative study by interviewing key people. Three provinces including Qinghai, Henan and Shandong have been chosen as our study sites with purposive sampling. In addition, provincial and county level leaders will also be interviewed. We critically assess the actual purchasing performance by comparing it with ideal strategic purchasing mechanism, recognize hindering factors which influences the system's performance, and finally propose suggestions for policy making. Results: The results indicate that the accessibility, efficiency, and quality of primary health services in present China are low. Practice of strategic purchasing is limited and the purchasers could not fully represent community's preference. Meanwhile, purchasers are lack of control on healthcare providers and stewardship of government is not adequate. Conclusions: Enhancement of strategic purchasing mechanism needs to better coordinate principle-agent relationships between different actors, create appropriate incentives by adopting mixed provider payment methods and contracting with providers. Key words: Strategic purchasing; multiple principal-agent model; financing; people preference
Rural-to-urban migration and its implication for new cooperative medical scheme coverage and utilization in China

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ABSTRACT

Background China has been experiencing the largest rural-to-urban migration in history. Rural-to-urban migrants typically find better job opportunities and get higher salaries in cities. This has served to improve the enrollment rates in the New Cooperative Medical Scheme (NCMS). However, current regulations stipulate that people who are registered in rural hukou can only participate in their local NCMS, which in turn poses barriers when migrants seek medical services in the health facilities of their destination cities. To examine this issue in greater depth, this study examined the associations between migration, economic status of rural households, and NCMS enrollment rate, as well as NCMS utilization of rural-to-urban migrants. Methods Our sample included 9,097 households. Chi-square test and T-test were used to examine differences between the two populations of migrants and non-migrants based on age, gender, marriage status, and highest level of education. Ordinal logistic regression was used to examine the association between migration and household economic status. Binary logistic regression was used to examine the associations between household economic status, migration and enrollment in the NCMS. Results Migration was positively associated with improved household economic status. In households with no migrants, only 11.3% of the population was in the richest quintile, whereas the percentage was more than doubled in households with family members who migrated in 2006. Among those using in-patient medical services, 54.3% of migrants in comparison with 17.5% of non-migrants used out-of-county hospitals, many of which were not designated hospitals; and 55.2% of migrants in comparison with 24.6% of non-migrants, who had the NCMS in 2006, received no reimbursement from the NCMS. Conclusion Migrants to urban centers improve the economic status of rural household economic of origin. However, obtaining reimbursement under the current NCMS for the cost of hospital services provided by undesignated providers in urban centers is limited.
Insights from Afghanistan: Effects of performance-based payments on health worker motivation and quality of care

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ABSTRACT

Background: We evaluated a Results-Based Financing project aimed at improving health system performance by incentivizing providers at 442 randomly assigned facilities in 11 provinces of Afghanistan. Treatment consisted of quarterly payments to health facilities based on verification of performance. Methods: The study is based on a cross-sectional survey of 2,180 patients, 805 health workers, and 233 facilities conducted 23 months after the start of the intervention. We estimated intention-to-treat and complier-average causal effects using latent variable modeling framework. Results: Intention-to-treat estimates indicated an increase of 0.23 standard deviations in clinical quality of care (p-value<0.05) for patients observed in intervention facilities as compared to those in control. Contrary to expectations, we found no effects on health worker motivation (p-value>0.05). Furthermore, the complier-average causal effect of PBP on motivation was negative. Discussion: While PBP program participation is a significant predictor of quality of care, the intervention explains only a small proportion of variance in quality between as well as within facilities. Factors such as presence of functioning equipment and timely payment of salaries appear to be more important predictors of quality of care, explaining a higher proportion of observed heterogeneity in quality. This suggests that PBP should be paired with other complementary quality improvement activities. Several program design issues explain the lack of effect on motivation, including heightened expectations not met due to relatively small size of incentive payments in proportion to total salaries, payment delays undermining the perceived link between performance and payments, and lack of accompanying efforts to improve working conditions at facility level. The study identifies specific aspects of the PBP program design and implementation where changes could be made. It also demonstrates how developments in causal inference approaches and latent variable modeling techniques can be used in research on human resources and financing in developing countries.
Coverage and household benefit of Cambodia's innovative health equity funds for the poor - a quantitative analysis of beneficiary membership data

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ABSTRACT

Title: Coverage and household benefit of Cambodia's innovative Health Equity Funds for the poor - a quantitative analysis of beneficiary membership data. Background: Cambodia's Health Equity Funds (HEFs) are a unique approach to equitable health financing. Now covering three-quarters of the poor nationally, district HEFs were first established in 2000 to provide access to hospital care at public referral hospitals and later included health centres. HEFs are currently the principal vehicle for social protection and universal coverage in Cambodia. Methods: We performed the first comprehensive national quantitative analysis of HEF membership data, analysing more than 2 million records together with cost data. Preliminary analysis was based on frequencies with chi-square test and logistic regression. Results: Overall, HEF schemes cover 2,770,000 members; 31% are very poor and 62% poor households. Since 2000, approximately 40% of members have accessed public care. The percentage of HEF-supported admissions at hospitals and health centres increased steadily to 36% of all admissions in 2011. Health centres accounted for 84% of all contacts, most frequently for malaria (52%), deliveries (7%), and dengue (3%); and hospitals for 16%, for respiratory diseases (14%), deliveries (10%), and diarrhoea. In 2013 HEF covered 51 of 81 (63%) of all health districts. Since 2000, HEFs have supported 1,315,642 consultations and >30,000 deliveries (or 47.1% of expected births by the poor). Average cost per HEF beneficiary in 2013 was US$3.64 across health centres and hospitals (range US$1.15-8.89 in different districts). 82% of expenditure was on direct benefits and 18% on administration. Discussion: The HEF model is people-centred, benefits poor households and is effective as a health financing mechanism. Utilisation patterns, non-financial barriers, disease patterns and cost fluctuations will be further investigated. Administration treatment costs are sustainable, and the district-based HEF model is replicable and amenable to rapid scaling up.
Analysis on the benefit equity of rural hospital delivery subsidy program in China

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ABSTRACT

Background China is on track to achieve MDG5 but proven inequalities existed between urban and rural areas. In January 2009, the Chinese Government carried out Rural Hospital Delivery Subsidy (RHDS) program to improve rural hospital delivery rate. How does RHDS work? Which payment method is the best for RHDS? To answer these questions, we conducted a survey in March 2011. Methods The household survey was conducted in four counties: Guangling of Shanxi Province, Xiji of Ningxia Province, Bijie of Guizhou Province and Zhouzhi of Shaanxi Province, with provider payment methods of fee for service, capitation payment, single disease payment and single disease payment with restriction of cesarean section rate respectively. 4836 rural women who gave birth from 2005 to 2010 were selected by stratified random sampling, with 6204 parities in total, including 4013 parities before RHDS and 2191 parities after RHDS. Results Hospital delivery rate was 65.7% before RHDS and 89.3% after the implementation of RHDS program (P<0.001); accordingly, subsidy for each hospital delivery was improved from 33.5 to 103.5 US dollars on average (P<0.001). The effect of RHDS was still significant on both delivery rate (OR=1.1, P<0.001) and delivery subsidy (P²=1.7, P<0.001) controlling over demographic and socioeconomic characteristics. The horizontal inequity (HI) index of delivery rate decreased from 0.0144 (P=0.029) before RHDS to 0.0130 (P=0.003) after RHDS, which of delivery subsidy dropped from 0.0392 (P=0.002) to 0.0081 (P=0.309). Similar trends were found within four payment methods; and single disease payment with restriction of cesarean section rate performed significant pro-poor trend of benefit degree (HI=-0.222, P=0.090) in the implementation of RHDS Program. Conclusions RHDS program is effective in enhancing benefit equity for rural pregnant women of different living standards; single disease payment with restriction of cesarean section rate is the most equitable payment method for hospital delivery.
Which mothers bypassed nearer facility under the cash transfer program? - A network analysis from Madhya Pradesh, India

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ABSTRACT

Background: Timely access to emergency obstetric care (EmOC) can prevent maternal deaths. In the province of Madhya Pradesh (MP), India government provides free transport for parturients to deliver in the obstetric care facility (OCF) of their choice. However users tend to bypass their nearest health facilities, which is costly for the health system in terms of travel costs. On this background we aim to study the bypassing behavior among rural parturients in three districts of MP using Geographic Information System (GIS).

Methods: Facilities which performed >10 deliveries/month (n=96) were visited for 5 consecutive days to interview post-natal rural women (n=800). Their address, socio-demographics, transport and delivery details were recorded. The locations of mothers and facilities were plotted in GIS to calculate their distances from the nearest facility and chosen facility using network analysis. Mothers who did not deliver in the nearest facility from their residence were considered as 'bypassers' and compared with non-bypassers. The performance of EmOC signal functions was studied to compare bypassed and preferred facilities.

Results: Total 357 (44.63%) mothers bypassed the nearest facility. Bypassing was significantly higher among educated, primigravidae and users of hired transport. Bypassers travelled significantly longer distances (median 16.62 km, IQR 10.74 - 22.38) than non bypassers (median 5.50 km IQR 2.75 - 9.66 km). Private OCFs were most frequently bypassed facilities; followed by the primary and secondary level OCFs in public sector. Mothers bypassed these facilities to deliver at the district level public sector hospitals (DH). The performance of EmOC signal functions was poor at primary and community health centers as compared to DH and private facilities.

Conclusion: Nearly half mothers bypassed nearest facility. Bypassing was significantly higher among literate women who paid for the transportation themselves. The findings indicate that the mothers seek for better facilities bypassing the nearest facilities travelling significantly longer distances.
The cost of bypassing small hospitals in a 'free' health system: A cross sectional study in Sri Lanka

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ABSTRACT

Background: Rising out-of-pocket expenditure for health, resulting from policy issues is a major factor contributing to deterioration of efficiency and equity of healthcare systems. Bypassing of small hospitals is one such policy issue in Sri Lanka, where health is provided free at point of delivery in all public hospitals. The objective of this study was to estimate the effect of bypassing divisional hospitals in Sri Lanka, on the direct out of pocket costs of the patients

Methodology: This study employed a hospital based cross sectional analytical design. Two divisional hospitals (primary care) and a general hospital (referral level) were used as the study settings. One hundred and twenty patients who bypassed the two divisional hospitals and attended the general hospital were identified using a screening tool and a map of the area. Out of pocket costs of this cohort of patients were assessed using an interviewer administered questionnaire and compared with a similar number patients who did not bypass the divisional hospitals. The assessment of costs involved direct questioning and subsequent calculations based on unit costs. Bivariate analysis of the out of pocket expenditure was performed using the Mann-Whitney test, placing the level of significance at 0.05. Results: The mean out of pocket expenditure for travelling of bypassed patients and their family members was more than four folds higher than those who did not bypass (p<0.05). The out of pocket expenditure on meals and snacks was also higher among the bypassed. The bypassed group spent, about SLR 63 more per visit, than their counterparts who did not bypass (p<0.05). Conclusion: Bypassing significantly increases the state health expenditure and the out of pocket expenditure for health. Policy options such as establishing draining areas, bringing up referral policies and improving facilities at lower level hospitals need to be implemented to reduce bypassing.
Impact of funding modalities on achieving universal health coverage in Zambia; a focus on maternal child health interventions

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ABSTRACT

Background: Recently the drive towards universal health coverage has gained momentum, with diverse stakeholders working in tandem to achieve the set targets. Zambia like many countries in the sub-Saharan Africa has witnessed concerted efforts towards universal health coverage for key health interventions over the last decade. Objective: To determine the impact of different funding scenarios on the achievement of universal health coverage in Zambia. Methods: We compiled a database comprising of coverage trends for key maternal and child health interventions for the period 2004 to 2009. Using the Arellano- Bond difference GMM model we then estimated the effect of different funding channels on the composite intervention coverage for maternal and child health services. Subsequently, we estimated the intervention coverage attainment associated with different levels of donor and government funding over a 6 year and 10 year period. Findings: A 60% annual increase in funding channeled through the government system would lead to the achievement of overall intervention coverage of 85% for key maternal and child health interventions within a 6 year period. On the other hand, a 60% annual increase in funding disbursed directly by donors would take over 9 years to achieve a similar effect. This could be due to the unpredictable nature of donor financing in Zambia both in terms of volumes and timing of the disbursements. Conclusion: Funding channels have an impact on health intervention coverage. In Zambia, Government channels would have a greater impact on coverage attainment in comparison to donor channels. This could be attributed to the unpredictable nature of donor financing in Zambia both in terms of volumes and timing of the disbursements. Greater harmonization of funding channels from multiple sources into a single framework would help to accelerate efforts towards the attainment of universal health coverage in Zambia.
Increasing the fiscal space for health: the experience of Kenya, South Africa and Lagos State (Nigeria)

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ABSTRACT

Background Health financing debates currently focus on new sources of revenue yet increasing general tax allocations to Health is another, potentially more progressive, option. This paper compares case studies from Kenya, South Africa and Lagos State (Nigeria) where, over the past decade, general tax revenue has increased. It analyzes how the three countries transformed their tax collection capacity and the implications of improved 'fiscal space' for Health. Methods Country research teams developed a common data collection and analytical approach based on two conceptual frameworks for understanding the dimensions of tax collection capacity and budget allocation policy within quasi-federal and decentralised health system contexts. For each case study, a mixed methods approach was used including a document review, trend analyses of quantitative data on government revenue and expenditure, and a thematic content analysis of semi-structured interviews with a purposive sample of key stakeholders involved in government revenue collection and sectoral budget allocation policy and implementation. Finally, a cross-country comparison was conducted using the conceptual frameworks. Results Macro-economic policy influences the size of the government budget. Further, improving tax collection requires not only transformation of the legitimacy, management, enforcement capacity and consumer orientation of the tax collection agency, but close interaction with Treasuries and adequate political support. Increased tax revenue does not necessarily lead to improvements in allocations to Health. Ministries of Health often do not have the technical capacity, political clout or implementation track record to argue for larger allocations. In addition, unwieldy budget cycles, fiscal federalism and health systems decentralisation narrow the fiscal space for Health. Conclusions Fiscal space for Health is constrained by many factors even where political support is strong. Ministers of Health must strengthen their ability to negotiate with Cabinet colleagues and the President for larger allocations, including demonstrating the economic and social benefits of Health investments.
The impact of the policy to reduce out-of-pocket payment on cancer screening in South Korea

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ABSTRACT

Background: Korean government has provided free cancer screening services for low-income people since 1999. This study investigated whether the program reduced both relative and absolute income-related inequality in the uptake of cancer screening. Methods: Using the Korea National Health and Nutrition Examination Survey from 1998 to 2012, we examined whether income-related inequality in the uptake of screening has decreased over the time and whether it decreased at the recommended initiation age using regression discontinuity model, for breast (BC), colorectal (CRC) and gastric cancers (GC). Results: First, we found that while overall screening rates increased and relative differences between highest-income and lowest-income quartile decreased significantly in post-policy period compared to pre-policy, absolute inequalities rarely changed and increased from 9 to 14 percentage points in the uptake of screening for CRC among men with a marginal significance. Second, the regression discontinuity results showed that absolute inequalities did not change for BC and CRC but increased from 5 to 16 percentage points for GC while overall rate increased and relative inequality significantly decreased at the initiation age. Discussion/Conclusions: The program led to no change or increases in absolute disparity while relative disparity in cancer screening decreased although NCSP provides free cancer screening for low-income people. Our results indicate that the policy to reduce out-of-pocket payment alone is not likely to reduce or eliminate inequalities. Further researches are needed to investigate barriers that prevent low-income people from the uptake of cancer screening.
Financing health care in Nepal

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ABSTRACT

OBJECTIVES: To review and assess the current practices of financing health care in Nepal, and draw possible alternative strategies for the payment along with delivery of efficient and equitable health care.

METHODS: Literature reviews on the financing mechanisms and their compatibility to deliver efficient health care, globally, and current practices in Nepal.

RESULTS: Nepal’s total expenditure on health (TEH) is still below 10% of the gross domestic product, albeit marked improvements in health outcomes in the last 10 years. About 62% and 17% of the total population meet their health expenses by out of pocket (OOP) payment and government funded social health insurance (covering civil servants and maternal health services), respectively; remaining are supported donor funding. Whilst, 0.4% of private expenditure on health is supported by prepayment (private) plans, a huge population remains uncovered with any protective plans.

CONCLUSIONS: As no country has a single mechanism to finance health care, the challenge of choosing unsurpassed payment module is almost imputable. With large proportion of TEH dominated by OOP payment, it has huge implications in efficiency and equity of health care services at different levels. As improvements in national economy and large urbanization might be a long term plan, increasing reliability and dependability on tax financing can be an immediate measure to reduce dependence on OOP payment. Scrutinizing the community health insurance programs and their promotion, along with close monitoring of successful social health insurance in developed countries may be judicious to strengthen equitable health care. Weakening governance, fragile political leadership and paucity in honesty among the stakeholders has propelled social health insurance far beyond the reach for the Nepalese population. Moreover, there is an utmost need to restructure available resources from high-cost, low-impact interventions to low-cost, high-impact essential health care services, while improving effectiveness and efficiency.
Equity in geographic resource allocation in Mozambique: an extension of benefit incidence analysis methodology

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ABSTRACT

Background: Resource allocation is fundamental to an equitable provision of health care services. Equity in public health expenditure has been analysed using resource allocation formulae (RAF), helpful ex-ante to allocate resources across spending units, or using benefit incidence analysis (BIA), which evaluate ex-post the distribution of benefit across service users. We use BIA in an innovative way to assess horizontal and vertical equity in the geographic allocation of outpatient recurrent expenditure in Mozambique. Methods: First, we compare the actual distribution of benefit with the benchmarks for horizontal and for vertical equity, by ranking individuals according to economic status and need for health care, respectively. Second, we disentangle the contributions of individual service use and district resource allocation to the observed inequity. Third, we repeat the analysis for government and donor expenditure, separately and combined, for the years 2008 - 2011, to identify differences in targeting and describe patterns over time. We use national routine data from a number of sources. Results: Results show improvements in both horizontal and vertical equity, along with the alignment of government and donor resource allocation over time. While horizontal inequity is driven by service use, vertical inequity derives mostly from resource allocation. The discrepancy between individual ranking based on economic or need indicators evidences initial differences in government and donor expenditure targets, which reduce over time. Discussion: Our results challenge the objectives of public health expenditure and confirm the need to clearly define the equity objectives and the target population to evaluate and inform resource allocation policies. We suggest a method to evaluate and monitor equity in the geographic allocation of public expenditure. However, further understanding of inequality in health care utilization and absorptive capacity of local administrations is required to advance the debate on equity in resource allocation and to inform policies that effectively and efficiently respond to people’s needs.
Economic burden of patients with pulmonary tuberculosis in a highly developed county of China

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ABSTRACT

Objective China has implemented a free-treatment policy for tuberculosis. However, previous studies showed that patients had to pay a substantial proportion of their annual income for tuberculosis services. This study aims to measure the economic burden on tuberculosis patients and to analyze factors contributing to this burden in a rural area of China. Methods We chose Zhangjiagang, a highly developed county, as the study area. Twenty three villages were selected based on a cluster sampling method. Three hundred and forty patients who were diagnosed as pulmonary tuberculosis since January 2010 and had already completed the standard anti-tuberculosis treatment before March, 2013 were invited for the investigation. Patient's economic burden due to the disease was analyzed and the influencing factors were explored. The economic burden included two parts: direct costs and indirect costs. Direct costs included medical costs related to tuberculosis diagnosis and treatment (clinical and hospitalization expenses), transportation, accommodation and food costs. Indirect costs were calculated as loss of income due to inability to work following tuberculosis. Results The average annual income of patients was 19 159.9 yuan and the median income was 15 000 yuan. The average total cost was 18 793.3 yuan and the median (inter-quartile) cost was 9965 (3200-24 400) yuan. Per capita direct cost was 11 936.9 (median: 4590) yuan. After excluding costs covered by health insurance, the per capita out-of-pocket cost was 7448.0 yuan, with the median of 3315 yuan. The per capita indirect cost was 6856.4 (median: 1575) yuan. Factors associated with the economic burden included hospitalization, taking liver protective drugs, using the second line anti-tuberculosis drugs, and diagnosis delay, etc. Conclusion Although the government of China has established a 'free TB service policy', the financial burden on patients was still heavy. More patient-centered interventions are essential to reduce economic burden on patients.
Where is the patient welfare factor in the formula? Impact evaluation of district hospital capitation payment in Vietnam

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ABSTRACT

Over the last decade, universal health coverage schemes in many developing countries have made appreciable progress in expanding population coverage. Yet provider payment reform remains a major challenge. Incentive setting focusing on cost containment may come at the expense of quality, equity, and patient welfare. The current paper illustrates this case by evaluating the impact of a policy to use capitation contract with district hospitals in Vietnam. We use hospital panel data combined with population survey data over the period 2005 - 2011 to estimate capitation impacts on efficiency, quality, and equity. We employ hospital fixed effects model to rule out the confounding effects of hospital specific factors and perform multiple analyses to test the results' sensitivity to different data combination. We find that capitation has improved hospital efficiency, as measured by recurrent expenditure and drug expenditure per case. At each combination of service outputs, capitation resulted in nearly 5% reduction of total expenditure. While no adverse effect on health outcomes was observed, the effect on equity raised a real concern: hospitals scaled down service provision to the insured and increased provision to the uninsured (who continue to pay out-of-pocket on a fee-for-service basis). The value of drugs used per insured patient decreased by more than 21% and there was also a reduction in fee exemption at the discretion of the hospitals. Our study clearly points to the importance of careful consideration of intended and unintended consequences in designing provider incentives. While hospitals do respond to cost constraints by improving efficiency, they have shifted the financial risk to the uninsured population. By illustrating the Vietnam case, our paper addresses an important gap in understanding the effects of provider payment and will be useful to many countries, which are struggling to find a balanced purchasing model in health care.
10 Best resources on universal health coverage

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ABSTRACT

Background: As the deadline for attainment of the Millennium Development Goals draws closer, the World Health Organization is seeking to provide leadership in setting the post-2015 development agenda regarding health by prioritizing Universal Health Coverage (UHC). The purpose of this paper is to track the evolution of Universal Health Coverage and provide a list of ten resources that describe what it entails, its feasibility, possible merits and demerits as well as explore the available evidence concerning effective scaling for its attainment to meet population health needs. As UHC takes its place as a universal framework for Health systems development, the need for individuals involved in health policy both at national and regional levels to understand these principles could not be more imperative. Methods: A rigorous literature review was done exploring Scopus, EconLit, Global Health Library, Worldwide Political Science Abstracts and CINAHL databases from January 2000 till December 2013. Studies on single countries were excluded and ten current, relevant, peer-reviewed articles including quantitative and descriptive literature were selected which provide a comprehensive perspective regarding critical facets of UHC. Results: Ten key resources are proposed that clarify the major principles of UHC, explore its potential as well as challenges in its attainment and the contentions that pertain to it. Discussion and Conclusion: Universal Health coverage has potential gains especially for society's poorest as it can enhance access of services and provides financial risk protection. However, given heterogeneities in country health needs and priorities, local adaptation for establishment of people-centred context-appropriate systems is crucial. The fragility of UHC's antecedence in global discourse can be averted by ensuring further research to ascertain how countries can appropriately measure progress, address the dynamic needs of their populations and create sustainable mechanisms to withstand the growing global increases in medical expenses.
The need of investing in supply side to increase health service coverage in vulnerable areas: lessons learned from user-fee exemption implementation in Papua

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ABSTRACT

Background Indonesia has started implementing national health coverage (NHC) in January 2014 by pooling all existing public health insurance into centrally-managed system. Before the implementation of NHC, Papua has enacted universal health coverage for all Papuan population. However, the improvement of healthcare coverage, i.e. maternal-related care was poorer compared to other provinces without such coverage. Even after the implementation of user-fee exemption for maternal and children conditions, the increase of maternal care coverage in Papua was poorer compared to other better-off provinces. Thus, it is important to identify factors that could have discouraged the improvement of health service coverage in vulnerable areas in the NHC era. Methods Descriptive case study using bottleneck framework was performed to collect data on supply and demand aspect of health systems. Results In Paniai, one of district in Papua, the utilization of antenatal care, skilled-attended and facility delivery was quite low (27%, 15% and 6%, respectively) with small improvement before and after the implementation of universal health coverage for obstetric cases. This could be attributed to limited health supplies, i.e. only 1 CEONC and 1 BEONC (comprehensive and basic emergency obstetric neonatal care) to serve all population in a district, lack of emergency equipment in the BEONC facility, no staff had been trained for CEONC or BEONC, and only 47% village had midwives. Conclusion and Recommendation Demand-side intervention alone appeared to be inadequate to address low healthcare utilization in vulnerable areas. The case study shows that there is a risk of NHC underutilization and disadvantages related to centrally-pooled systems for vulnerable area like Papua due to limited health facilities and lacking number of health workers. To avoid unfavorable implication of centrally-pooled systems, it is critical for the central government to allocate more money to improve the quantity and quality of health supplies in vulnerable areas.
The impact of insurance coverage for hospitalized care on out of pocket expenditures in Ri Bhoi district of Meghalaya, India

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ABSTRACT

Insurance coverage for hospitalized healthcare services for poor was introduced by the Government in Ri Bhoi district in 2011 with an objective to reduce household out-of-pocket-expenditures (OOPE) for these services. Each enrolled household (5 members) are entitled to insurance coverage of Rs.30000 (600 USD) per annum on a floater basis. However, there is no age limit and all pre-existing conditions are covered. The individual does not have to pay any money directly to the provider while seeking treatment. Hence it is expected that OOPE during an episode of hospitalization among insured is either nil or negligible or at least less than those poor (BPL) individuals who are uninsured. To ascertain if this insurance coverage has such an impact, we compare the OOPE among insured and uninsured poor (BPL) individuals in Ri Bhoi district. Analysing merits/demerits of the program would enable corrective measures and also provide evidence based direction for policy making on UHC in the country. The study is based on data from a district household healthcare utilization and expenditure survey conducted in Ri Bhoi district from May 2013 to July 2013. This is a multi-stratified random sample survey covering 978 households (5710 individuals). OOPE for hospitalized care was collected for a recall period of one year for all the households. From this data base, 2098 individuals categorised as poor (belonging to BPL category) were segregated. Amongst these, 167-hospitalization episodes were reported in last one year. Within this group of reported episodes, two sub-groups were created. Subgroup-A composed of 111 episodes covered by insurance and Subgroup-B composed of 56 episodes with no insurance coverage. OOPE on hospitalized care between these sub-groups was compared. The analysis shows no statistically significant difference (95% confidence interval) between OOPE during hospitalization of the insured and the uninsured.
Are Kenya’s informal sector economic activities sustainable to finance universal health care? A cross-sectional analysis

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ABSTRACT

Background: Faced with critical financial constraints and large informal sector populations, many developing countries find it difficult to progress to universal coverage. Universal coverage requires predictable and dependable financing and given limitations of public funding of health care and the assumption that the informal sector has financial resources, it is important to understand whether these resources are sustainable over a period of time in cases where the informal sector is required to prepay for health care. Objectives: To describe the nature of the informal sector in Kenya, and to critically analyse the financial potential and sustainability of informal sector activities in selected counties of Kenya. Methods: Data collection involved document reviews, mapping informal sector activities, focus group discussions, in-depth interviews and questionnaire cross-sectional survey. Analysis involved constant comparison for qualitative data and Stata 11 for quantitative data. Results: Enterprises with a lifespan of five years at the time of survey were regarded as sustainable. Of the fifteen different industries identified, food vending (23%) dominated in the urban area while farming and livestock dominated the rural area. Sustainability of non-agricultural informal sector activities is low (43% urban and 44% rural) but about 84% of agricultural informal sector activities were found to be sustainable. Owning land was the main predictor of sustainability of the informal sector in the rural area. Without land, enterprises are 0.04 times likely to be unsustainable (P=<0.001). Some key predictors of sustainable enterprises in the urban area included gender (OR=2.26 and P=0.01), having an employee(s), ownership of premises (OR=1.52, P=0.26), monthly consumption and marital status. Conclusion: Informal sector is highly diversified but sustainability of non-agricultural informal sector is quite low, indicating a volatile economic environment with unpredictable income for most activities. Furthermore, high numbers of food-vendors in the urban area indicate widespread poverty in the sector.
Confronting resistance: A review of material incentives as a strategy to improve TB treatment adherence and prevent the emergence of drug resistance

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ABSTRACT

A decade since the establishment of the Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria, the WHO reports that TB still ranks as the second leading global cause of death from an infectious agent, with an estimated 8.6 million new cases and 1.3 million deaths in 2012. Future progress is threatened by rapidly growing resistance to the most effective TB therapies, which is transforming tuberculosis from a curable ailment into an uncontrolled global health threat. Because drug resistance is often caused by a patient's previous poor adherence to first-line treatment's and because treatment of multidrug resistant (MDR-) and extensively drug resistant (XDR-) TB is characterized by high costs, complex regimens, long duration (typically within a hospital setting), toxic side effects, and low success rates, improving adherence and stemming the tide of drug resistance is an urgent challenge for health systems. In light of this challenge, this analysis reviews the effectiveness and feasibility of material incentives as one strategy to improve patient adherence and prevent the emergence of drug resistance. First, it describes the context and history of material incentive programs for TB treatment. Second, it reviews the quantitative and grey literature evidence base for their effectiveness, finding a limited but encouraging body of research. Finally, it discusses the policy implications of the evidence for future research and utilization, with due consideration to ethical and cost-effectiveness dimensions.
Policy implications of a government sponsored health insurance scheme for tertiary care: A study from Andhra Pradesh, India

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ABSTRACT
Inequities in medical access and affordability have been under-addressed in many lower income countries, leading to many recent reforms towards universal health coverage. Accordingly, the state government of Andhra Pradesh (AP) in India pioneered the state-funded Rajiv Aarogyasri Health Insurance Scheme to provide treatment for serious and life-threatening illnesses beginning in 2007, with the objective of protecting poor households from the financial risks of low-frequency, high-cost tertiary care. To compare the effects of this innovation on access and expenditure on hospital care, we surveyed 8623 households in Andhra Pradesh and 10,073 in the state of Maharashtra (using the 2004 National Sample Survey data as a baseline). By conducting a cross-sectional difference-in-difference study we aimed to compare Aarogyasri versus those found in Maharashtra, including the National Health Insurance Scheme, with a comparatively lower utilization and coverage. We find that average inpatient expenditure rose significantly in Maharashtra, whereas hospitalization rates increased more in AP (although duration of stay declined). Utilization of private facilities has increased in AP while remaining steady in Maharashtra (with the share of public facilities decreasing in both states), and overall inpatient expenditure for private facilities has increased in both states. The focus of this session would be to discuss the policy implications of these findings and strengths and weaknesses of schemes funding solely tertiary care.
Health seeking behavior and impact of health financing policy on household financial protection in post conflict Cambodia: A life history approach

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ABSTRACT

Cambodia has experienced over two decades of conflict between 1970-1991, with outbreaks of violence continuing until the end of the 1990s. Since then, the country began to rebuild its health system, supported by diverse forms of health financing including out-of-pocket payments (OOP) through formal user fees (UF), community-based health insurance (CBHI) and health equity funds (HEF). This study addressed two objectives: first, to explore the behavior pathways followed by Cambodian people in accessing healthcare from 1950s to the present and analyse the factors that influenced their decisions; second, to identify whether pro-poor health financing policy such as UF, CBHI and HEF contributed to household financial protection for the poor and near poor. A life history approach was used to collect information on episodes of illnesses, deaths and births and on health spending history through in-depth interviews with 24 participants from Phnom Penh and Takeo province. Preliminary findings showed that since 2000s there had been a change in health seeking patterns, from relying on traditional birth attendants (TBAs) to public facilities for birth delivery. This trend- moving from reliance on indigenous practitioners, towards greater use of private healthcare and public/NGO facilities -was found across all health seeking behavior. The findings show mixed results regarding whether the UF, the CBHI and HEF contributed to protecting the poor and the near poor from catastrophic health costs. With the retrospective view offered by life history, it becomes clear that while the government health system was in transition of rebuilding, TBAs, indigenous practitioners and village medics had filled the gap in providing services. The findings also suggest that the impact of the different financing schemes depended on the poverty level in each household, chronicity and severity in the type of illness they had and implementation of the schemes.
Public health expenditure and infant mortality: panel threshold regression analysis of 189 countries

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ABSTRACT

Background: To achieve the target of infant mortality proposed in UN Millennium Development Goals, how much should public health expenditure of a nation be? This research adopted the panel data (1995-2012) of 189 countries from World Bank Development Indicators to estimate the threshold effect of public health expenditure on infant mortality. Methods: First, methods of neoclassic economics were used to analyze whether convergence and convergence existed in time tendency of infant mortality. Second, fixed effect model of infant mortality was used to estimate the marginal effect of public health expenditure. Third, panel threshold regression model was used to estimate threshold value. Fourth, OLS model was used to estimate the marginal effect of public health expenditure on infant mortality in different intervals determined by threshold value. Results: Though the infant mortality dropped from 44.79% in 1995 to 24.85% in 2012, yet convergence and convergence did not exist over time. The analysis of fixed effect model indicated that a 1% increase in public health expenditure as a share of GDP is associated with as many as 0.869% decrease in infant mortality. The panel threshold model manifested that the effect of public health expenditure as a share of GDP on infant mortality exist two threshold values: 1.926% and 6.62% respectively. Less than 1.926%, the impact of public health expenditure on infant mortality would be not significant; between 1.926% and 6.62%, the marginal effect of public health expenditure on infant mortality would be -0.869; higher than 6.62%, the marginal effect of public health expenditure on infant mortality would be -0.197. Conclusion: UN Millennium Development Goals did not improve the equalization of infant mortality in member countries. Only when the public health expenditure achieve certain scale (more than 1.926% of GDP) can it exert positive impact on health outcome (infant mortality). With the increase of scale (more than 6.626% of GDP), the marginal effect decreases.
Costing the expansion of nursing production in Southern Africa to meet WHO health worker density targets

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ABSTRACT

Introduction: It is widely recognized that the lack of a trained workforce is a major barrier to scaling up health services. A number of the countries in the Southern African Development (SADC) are designated by the WHO as HRH crisis countries, facing severe shortages of physicians, nurses and midwives. Nearly all the HRH crisis countries are nurse-driven systems; they provide most of the care to patients, and many medical tasks have been shifted to their scope of work. This research attempts to estimate the cost of all Southern African countries to reach the WHO minimum target of nurse/midwife coverage by 2022 (1.8 per 1,000 people).

Methods: The method used is a deterministic cost-projection of future production of nurses and midwives and of the wage bill once the WHO minimum target is reached. These figures are compared to current health spending to define the relative viability of such aggressive plans. Results: At current rates of population and economic growth, most countries in SADC can afford the expansion of their nursing and midwifery corps without a substantial change in their health effort (health as a share of GDP) or a large infusion of foreign assistance. Conclusion: The political economy of HRH presents a difficult problem for politicians: because it takes a long period of time to produce one health worker, the investment requires a long-term perspective while politicians tend to focus on the short-term. While HRH is one of many priorities for politicians, it is also impossible for a politician to take credit for the something that will happen in medium-term (five years or so). Private sector engagement in this space (through cost recovery) might be one part of a solution to fund greater HRH production.
Issues and challenges in developing a people-centric essential health package in federal states

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ABSTRACT

Universal Health Coverage (UHC) is a widely shared global agenda with two fundamental goals: maximizing health impact and reducing impoverishment due to healthcare costs. Essential Health Packages (EHP) can be one way of improving efficiency and equity and a means to concentrate scarce resources on interventions which provides best value for money. In a federal state like India, the path to national UHC will be through progressive adoption by all states since health is state subject. It is therefore imperative to develop an Essential Health Package flexible to states needs and pragmatic in considering existing mechanisms in delivery. This research exercise involves development of an EHP for India to be piloted in four districts of two states. The paper examines a) the role of political and administrative structures in federal states in determining EHP frameworks and b) the issues and challenges in developing an EHP in states based on national and regional priorities using effective cost containment mechanisms. The first phase of this mixed methods study reviewed global evidence on EHP development from 12 countries. This was supplemented by a systematic analysis of national and regional data from Central and State Governments. The second phase involved a situational analysis of existing public health systems through a purposive sampling of health facilities at all levels of care. An EHP framework was developed in consultation with civil society and stakeholders at central and state levels. A comprehensive detailed list of services was iterated and a detailed costing exercise was performed using data from two sample districts to estimate the financial requirements at state and national levels for attaining universal health coverage. This research is significant for financing people-centred and equitable health systems by examining resource allocation for population-based provision of essential health services. Target Audience: Policy-makers, Implementers, Communities, Health System Researchers
Opening the black box: Process evaluation of results-based financing in Senegal

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ABSTRACT

Background: The Government of Senegal (GoS) is piloting Results-Based Financing (RBF) in 112 health facilities in two regions, seeking to motivate health workers, improve the quality of care, and strengthen the capacity of district and regional health teams. Facilities are rewarded for achieving a set of maternal, newborn, child health and disease prevention targets that reflect country priorities. Quality of care is considered when determining incentive payments. While preliminary service coverage impacts appear positive, it is unclear exactly how the RBF incentives are modifying facility management and health worker behavior. Methods: The GoS and the USAID-funded Senegal Health Systems Strengthening Program are conducting a process evaluation to elucidate success factors and implementation challenges for the pilot program. Using a mixed methods approach, the evaluation combines quantitative health information systems data analysis with semi-structured interviews and selected in-depth facility case studies. Results: Results, available in summer 2014, will describe the extent to which the Senegal RBF program is operating as designed and review enabling factors and barriers to implementation. Case studies will document the specific initiatives facilities have established to respond to RBF incentives. Key informant interviews will shed light on which factors account for variations in the performance of health facilities. Discussion: RBF programs are expanding all over the world, yet evidence is thin about the “black box” of exactly how they modify behaviors and why they work (or fail to work). This implementation research will inform the GoS, development partners, and the RBF community at large on the lessons learned and best practices of the program in Senegal. Results will inform the design and implementation of future RBF programs, and a potential scale-up in Senegal. The study contributes to the field by assessing how this alternative purchasing strategy can incentivize health workers for the provision of effective, quality services.
Analysis of hospital charges for 10875 inpatients with treatments of chemotherapy of malignant tumour in tertiary hospitals under the fee-for-service payment system

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ABSTRACT

Background: Malignant tumour has become one of the most harmful chronic noninfectious diseases in the world. In 2012, new cases of malignant tumour reached 14 million, and the number of patients died of malignant tumour amounted to 8.2 million, which had generated a serious health and economic burden to the society. As one of the three major treatments for malignant tumour, chemotherapy has been widely conducted clinically. In this study, the composition of total hospital charges for malignant tumour inpatients with treatment of chemotherapy in tertiary hospitals under the fee-for-service payment system and the influence factors have been analyzed, which aims to provide with a reference suggestion for medical reformation on hospital charges control and hospital charge payment system in China. Methods: Data was collected from the front pages of medical records (FPMR) of the two tertiary hospitals in Xi'an city, from January 1st, 2012 to December 31st, 2012. Information on inpatient charges was collected from computer files of these hospitals. There were 10 875 patients with a principal diagnosis of chemotherapy of malignant tumour. The influence of social and medical factors on total charges was analyzed with multiple regression model. Results: The proportion of medical fees of inpatient charges for chemotherapy of malignant tumour reached 74.85%, following were treatment fee and laboratory testing fee. With multiple regression, factors associated with hospital charge were length of hospital stay, proportion of drug fees, management of hospital, operation, health insurance, hospital admissions, accompanied diseases and gender. Conclusions: When the hospital department performance evaluation, the control proportion of medical fees of patients with malignant tumor chemotherapy should be raised. Measures of shortening the length of stay in hospital, a rational use of medicines and strengthening the management of hospital are regarded as the key features for an effective hospital charges control.
Intrinsic and workplace-related factors among facility- and community-based health workers in rural Mozambique to inform a performance-based incentive intervention

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ABSTRACT

Background: Frontline health workers are fundamental to reducing the burden of diseases including HIV/AIDS, and motivation is central to their performance. Performance-based incentives (PBIs) among health workers have demonstrated potential to improve services for vulnerable populations, but strikingly, the explicit role of health worker motivation in the pathway of these interventions has been largely overlooked. Furthermore, factors that motivate both facility- and community-based health workers providing HIV care have not been concurrently examined. Therefore, we characterized key individual and workplace characteristics that capture different aspects of motivation among facility- and community-based health workers who provide care to HIV-infected women and their infants in rural Mozambique. Methods: We assessed the motivation of 136 health workers [clinical health workers (n=66), community-based HIV volunteers (n=60), and traditional birth attendants (n=10)] using a survey incorporating phenomena germane to motivation identified in formative, qualitative work. Results: The majority of both facility- and community-based health workers reported feeling that they make a difference in their community (94% and 97%). Motivating factors for facility-based health workers included receiving constructive feedback from supervisors (53%) and receiving refresher trainings as often as needed (48%), while demotivating factors included working under high levels of pressure (72%) and dissatisfaction with salary (65%). Motivating factors for community-based health workers included receiving constructive feedback from supervisors (86%), while demotivating factors included lacking supplies (71%), and dissatisfaction with remuneration (46%). Discussion/Conclusions: All health workers reported high levels of internal motivation as well as demotivating factors including but not limited to remuneration. This suggests opportunity for PBI interventions to target a variety of aspects of the work environment beyond only remuneration to improve delivery of health services. This data will inform the development of an intervention to evaluate effects of PBIs on child health outcomes (e.g. growth, infection including HIV) in rural Mozambique.
Validating the extent of universal coverage in national health insurance program in Leyte Province, Philippines

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ABSTRACT

Background: This research developed and tested a protocol to measure and to validate the extent of coverage in the National Health Insurance Program (NHIP) of the Philippine Health Insurance Corporation (PhilHealth) in Leyte Province to promote universal health insurance coverage towards achieving universal health care. Method: Schools (active approach) and the updated List of Registered Voters (passive approach) were used in identifying individuals aged at least 21 years old. A one-page and pilot tested questionnaire was sent to and retrieved from target individuals through the students of participating schools. Validation of the survey results was done using PhilHealth database. In February 2013, 322,462 questionnaires were released in 268 schools in 14 local government units. In March 2013, 184,333 questionnaire were retrieved, and only 107,467 questionnaires were encoded. Meanwhile, the Comelec's List of Registered Voters for six LGUs yielded 304,888 target individuals in less than a month. Results and Discussion/Conclusion: NHIP membership in the province is 46% - 52%. Non-membership is a female phenomenon. Many who are eligible for membership are not members; others did not know they are members, and others thought they are members when they are not. Using the List of Registered Voters to identify the target individuals entailed less time and fewer resources but more number of target individuals identified. Using schools require relatively more effort and resource but lower number of target individuals identified. However, using the questionnaires in school increased awareness of the NHIP. Eligible individuals that were likely missed in the health insurance enrolment include those at least 21 years old that are not yet employed and the contractual employees in both the public and private spheres. They should be targeted for enrolment and a responsive policy to their situation should be formulated.
Staring into oblivion: The case of outside referrals in the Palestinian territories

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ABSTRACT

In fragile and conflict states, paying for patients to be treated outside the public health system can be an important strategy for covering the needs of the population. However, these referrals can pose a significant financial burden and have implications for equity. In the Palestinian Territories, expenditures on outside referrals grew more than ten times between 2000 and 2011, reaching US$125 million, a 36% increase from the previous year. This corresponds to 39% of the operational health budget. Most patients face mobility restrictions in neighboring countries, and utilization of referral services is unequal across governorates. We present findings of the Palestine Referrals Study (2009-2012) which aimed to improve the equity and efficiency of outside referrals by assessing the appropriateness of referrals and reviewing financing and administrative processes through 1) A qualitative review of the referrals process including key informant surveys and semi-structured interviews; 2) An analysis of the referrals and billing database; and 3) A medical audit where trained physicians reviewed a representative sample of the clinical files from the 13 most costly referred conditions. The initial estimates showed that 29% of reviewed referrals were not medically justified and about 60% lacked a clinical summary. Only 19% of the cases had bills or invoices in the financial database, while in 16% of reviewed referrals, there was a mismatch between the cases and bills. There were a large number of inappropriate procedures and long stays, particularly in Israeli and Jordanian hospitals. Estimates indicated that Israeli hospitals overcharged by 21.4 million dollars. Our findings have implications for the health sector including the development of a tracking and authorization system; development of procedures and guidelines for the referral committee; development of an audit function, for both the referral and for the procedure; and development of national capacity for high cost referral items.
Factors influencing basic and complementary health insurance purchasing decisions in Iran: Analysis of data from a national survey

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ABSTRACT

Background: Achieving universal health coverage is an important health system goal. Expanding health care insurance coverage is tool toward that goal. Insurance may reduce financial barriers to care and catastrophic expenditures. Understanding the factors that affect the expansion of health insurance is important for policy makers. We assessed variables that affected the decisions to purchase health insurance in Iran. Method: We analyzed data from a national survey of health care utilization in Iran that covered over 23000 households. We identified subsets of the data that represented purchasing decisions. We used logistic regression for analyzing Basic Health Insurance (BHI) and ordered logistic regression for Complementary Health Insurance (CHI). Result: Increasing age, education level and income, working in the government sector place and having another house increased the probability of purchasing BHI and CHI coverage. Past utilization of inpatient and outpatient care increased the probability of purchasing BHI and CHI, respectively. Conclusion: We observed evidence of adverse selection, and wide socioeconomic differences in insurance purchase decisions. Most factors significantly affecting health insurance were not easily influenced by policy decisions. The analyses suggest that it might be very difficult to achieve universal insurance coverage unless nationwide non-voluntary policies are implemented.
Using the introduction of the government employees medical scheme to assess the impact of the extension of health insurance on provider choice in South Africa

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ABSTRACT

Background In 2006 the Government Employees Medical Scheme (GEMS) was introduced and gradually expanded to previously uncovered public sector employees. Public sector employees who indicated that their employer provides medical scheme cover increased from 59% to 73% between 2007 and 2008, stabilising around 77% in 2011. Low-wage earning government employees were fully subsidized if they elected to join the lowest-benefit option within the scheme. By the end of 2012, GEMS provided health cover to more than 200,000 government employees and 1.8 million individuals. Methods The introduction of GEMS created a natural experiment allowing for the estimation of the causal effect of coverage on provider choices for female-headed and poor households (earning less than the R7000 threshold required to be eligible for the full subsidy). We exploit the gradual expansion of GEMS to implement an instrumental variable approach in the National Income Dynamics Study panel to identify the impact of an expansion of insurance coverage on a provider choice. Results We estimate the effect of medical insurance for those households whose choices were responsive to the GEMS subsidy. In female-headed households insurance resulted in a 48% higher likelihood (P<0.1) of consulting a private doctor over the last twelve months. In poor households, insurance increased the likelihood of consulting a private doctor by 89% (P<0.05) and reduced the likelihood of visiting public clinics by 86% (P<0.01). Discussion This analysis presents the most reliable indication yet of how an expansion of insurance may affect provider choice by lower-income households in South Africa. It reveals a strong preference for doctors over public clinics (typically staffed by nurses) under insurance. While the inclusion of networks of doctors will enhance user satisfaction, the observed magnitude of the shifts observed under insurance suggests that rationing measures will be critical for the envisioned NHI.
Pharmaceutical policies: effects of financial incentives for prescribers. A cochrane systematic review

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ABSTRACT

Background. The proportion of total healthcare expenditure spent on drugs has continued to grow in numerous countries of all income categories. We assessed the effects of pharmaceutical policies using financial incentives for prescribers on drug use, healthcare utilisation, health outcomes and costs. Methods. We systematically searched electronic databases till Oct 2012. We included randomised or non-randomised controlled trials, interrupted time series (ITS) or controlled before-after (CBA) studies. Two review authors independently assessed the studies eligibility for inclusion, risk of biases using EPOC criteria and extracted data from the included studies. All ITS results were re-analysed by the review-team. Results. Eighteen studies from six high-income countries met inclusion criteria. Fourteen studies evaluated pharmaceutical budget policies, three studies assessed pay for performance policies and one study assessed the reimbursement rate reduction policy. The ITS analyses had some limitations. All the CBA studies had serious limitations. No study from low-income or middle-income countries met the inclusion criteria. The findings suggested that pharmaceutical budgets resulted in a reductions in overall drug use, cost per drug item and drug expenditures (-2.8%, -25.6% and -38.9%, respectively). Effects on health outcomes were not reported. The effects of pay for performance policies on prescribing or health outcomes were uncertain. The reimbursement rate reduction policy study demonstrated small changes in prescribing. Conclusions. Although financial incentives are considered to be an important element of strategies to change prescribing patterns, limited evidence of effects exists. It is likely that drug budgets can decrease prescribed drug volume and drug expenditure. Effects of policies, including of pay for performance policies, on improving quality of care and health outcomes remain uncertain. Future studies should consider the impact of the policies on health outcomes rather than drug use only, and on overall health care expenditures rather than drug expenditures.
Heard about Sesame? Communication inequality as a determinant of access to social health protection in Senegal

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ABSTRACT

Background: The Plan Sesame, a Senegalese exemption scheme, was launched in 2006 to enhance equity through improving access to health care for older people. Research results suggest that less than 5% of the elders were covered. We hypothesize that access to information mediates access to SHP. Methodology: Based on a large scale household survey conducted in Senegal in 2012, we used an ordered logistic regression to compare three groups identified along a communication gradient: the informed on the SHP programme (25% of the sample) vs. the informed, but with little 'if any' retention of the information received (25%) vs. the non-informed (50%). We used qualitative materials 'mostly in-depth interviews with elders selected from the quantitative sample and other key stakeholders' to explore plausible causality patterns and the root causes of the observed communication gradient. Results: We observed several factors associated with the differential in access to and use of information across the three groups: the less informed, the less educated, the lower access to media, the lower participation in social events, the lower political participation, etc. Results also show that this differential also mediate activation of entitlements. We identify a parallelism between the observed communication gradient and the social gradient across the three groups. Likelihood to get and retain information is associated with several indicators of social, political and cultural exclusion, e.g. being poor, female, living in rural areas, with low political resources and limited social network. Discussion and conclusion: Qualitative data show why both the explicit and implicit communication strategy adopted to promote the plan failed to revert social inequities. Key enabling factors are proposed to develop an effective communication strategy, e.g. being gender- or ethnic-sensitive in the design of the communication plan. This concern is key to activate the mediating capacity of communication between social determinants and health outcomes.
Equity and effectiveness of fund allocation and spending for the national rural health mission in Uttarakhand, India

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ABSTRACT

Background: The National Rural Health Mission (NRHM) was launched in 2005 to expand access to healthcare for India's rural poor. Since that time, the NRHM's scope and funding has steadily expanded, but lagging capacity for planning and tracking may lead to disparities in fund allocation and use. The Policy Unit of the NIHF, the National Health System Resource Center, and the USAID-supported Health Policy Project partnered to examine the allocation and expenditure of NRHM funds at multiple program levels in the High Focus State of Uttarakhand. Methods: NRHM financial records for major program areas were analyzed for all districts in Uttarakhand and for facilities in three districts: Champawat, Haridwar, and Nainital. Allocations and expenditures were compared to health indicators and facility output data. Sources included NRHM records from fiscal years (FYs) 2008-09 to 2011-12, facility records from FY2010-11 to FY2012-13. Semi-structured interviews with key informants supplemented the analysis to aid understanding of barriers to planning, disbursement, and utilization. Results: The data reveal that wide disparities exist in per-capita fund allocations between districts, from ₹154 per person in Haridwar to ₹209 in Pithoragarh (FY2011-12), and these allocations were not correlated to health status. Districts and facilities routinely left 20-30% of funds unspent, indicating unrealized program potential. Interviews revealed that the most common barriers to utilization are lack of facility resources, particularly staff; delayed receipt; and misallocations. Across districts, spending on key MCH issues was poorly correlated to health needs. Conclusion: As the NRHM continues to expand, it must prioritize equity in financing to avoid exacerbating the already stark differences in health status across states and districts. Currently, the NRHM is missing opportunities to target beneficiaries with the greatest need and reduce health disparities, but this can be addressed through careful planning and fund tracking.
An alternative purchasing arrangement for priority health needs in a low-income setting: performance incentives for maternal and child health through results-based financing in Zimbabwe

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ABSTRACT

Background Increasing utilization of key maternal and child health services is an immediate need in Zimbabwe. However, purchasing cost-effective health services is a challenge in low-income country contexts; Zimbabwe’s weak healthcare delivery status and financial constraints require an alternative purchasing arrangement. Through the results-based financing (RBF) program, the Ministry of Health and Child Care purchases healthcare from public and private facilities through a performance-based incentive system, with an initial top-up payment for facility strengthening. Incentives are calculated considering the market price of the services and remoteness of the facility, and reimbursed upon the meeting of predefined indicators. We assessed the impact of the RBF program on utilization of key services in rural health facilities. Methods A quasi-experimental study utilized health management information system (HMIS) data to assess trends in the service utilization of key incentivized and non-incentivized services between March 2012 and June 2013 in 16 RBF districts and 16 matched non-RBF districts. HMIS data were collected for 24 months prior to program implementation to account for secular trends and seasonality. The quantitative results were substantiated by qualitative studies involving interviews with administrators, providers and clients. Results/Discussion The data show statistically significant increases in the utilization of incentivized indicators, e.g. outpatient and antenatal care, skilled institutional deliveries and family planning. The trends in the utilization on non-incentivized services were similar across all districts, indicating that providers did not neglect such services in the intervention districts. Stakeholders validated that an alternative purchasing arrangement using performance incentives can increase utilization of quality services and revenue of facilities, and enhance financial autonomy and community engagement. Clients reported longer operating hours and improved facility infrastructure. Conclusion Utilization of performance incentives as an alternative purchasing arrangement is an effective strategy to improve service utilization and health facility revenues in a low-income setting.
Achieving robust referral systems for reproductive health services in Honduras: opportunities for improvement

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ABSTRACT

BACKGROUND In Honduras, emergency case referrals from a community facility (primary level) to a more appropriate facility (secondary or tertiary level) that can offer necessary care and treatment remain a problem for cases of pregnant women, sick children and family planning users. We sought to identify why this referral system was not working, and to make recommendations for improvement. We compared our results with international experiences of improving referral systems in Guatemala, Mexico, Peru, and Argentina.

METHODS Primary research included direct observation of patients receiving care, interviews with providers and patients, and a review of registration papers/instruments at the sending and receiving facilities. Initial research was done in October 2013, and proposals and plans for improvement will be developed in early 2014.

RESULTS We found that the referral instrument is not uniform and not sufficient for the receiving provider. Stable referred patients do not have a set appointment at their referred health facility, and once they arrive are not attended to properly. Finally, once the patient is at the referred hospital, there is no way for the referring facility to follow up with the patient.

DISCUSSION/CONCLUSIONS Our results demonstrate the importance of referring only the cases that require referral to the most appropriate facility, and managing referred cases at both the original and receiving facilities. A clear referral process will reduce waiting times and will help patients and their families understand the process so that they can advocate for their own needs. Finally, a better information management system will allow for better management of referral cases, thereby providing more efficient and effective care. Specific recommendations:

- To better manage the patient at both the sending and receiving facilities, create Management/Planning Committees at both facilities
- Incorporate Information and Communication Technologies (eHealth) that simplify and facilitate the management of information between all parties
Beyond direct health expenditure: estimating the economic consequences of negative health shocks on rural households in China

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ABSTRACT

Background: Illnesses and injuries have been shown to be the most unpredictable and widespread risk for household income in the developing world. For households and individuals, ill-health is responsible for important direct medical expenditure, but also reduction in individual's earning capacity through loss of work days and productivity. McIntyre et al. (2005) show that combined, the total economic cost of illness for households can add up to over 10% of total household income. In addition, the extent to which these costs can trigger changes in livelihood strategies and welfare trajectories has seldom been subject to a thorough investigation in the literature. This piece of work aims at estimating the nature and magnitude of direct and indirect costs of illness, taking an original and much broader approach to cost of illness than in the 'traditional' health research literature. We also seek to investigate how different coping strategies can impact long-term household welfare following a negative health shock. This method is very relevant to developing countries, where the lack of formal social protection and credit markets is likely to trigger large costs outside of the health care sector.

Methods: This analysis is performed using a three year household panel survey data conducted in the province of Ningxia (Western China) from 2009 to 2012. In line with the existing literature, we use exogenous negative shocks to health constructed using both objective measures of health care access and indicators of subjective health status. We also seek to explore heterogeneity of impact by income groups.

Results: Households experiencing health shocks see a reduction of income (although not significant in all income levels) and an increase in health care expenditure, which constitute a significant double financial burden. We also investigate coping strategies at the household level and show that vulnerable households finance these costs partly through a reduction of food expenditure.
Seeking care for TB symptoms in South Africa: A longitudinal patient cost study

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ABSTRACT

Background A key aim of the post-2015 framework relates to financial protection. Understanding the economic burden associated with illness and accessing health services is key in identifying appropriate interventions. The aim of this study was to identify particular nodes in patient pathways where interventions could be targeted to reduce the economic impact on patients and households. Methods Two cohorts of patients accessing TB services from 10 clinics in the Gauteng, Mpumalanga, Free State, and Eastern Cape provinces in South Africa were surveyed. One cohort of 351 TB suspects were interviewed at the point of receiving a TB diagnostic test and followed up six months later. Another cohort of 168 patients on TB treatment, at the same 10 facilities, was interviewed at 2 months and 5 months on treatment. Patients were asked about their health seeking behaviour, the associated costs, income loss and any coping strategies used. Patients were recruited as part of the XTEND pragmatic trial. Results TB suspects spent an average of 45 days with at least one TB associated symptom prior to presenting for TB testing. The majority of costs incurred by patients were due to income loss. Income loss was most severe during the time between first experiencing TB associated symptoms and having a diagnostic test, with an average loss of $72.38 over the period. In contrast, there is only a patient reported increase in disability grant uptake during the continuation phase of treatment. Conclusion Enhanced or Active TB case finding strategies, where people are provided with regular reminders as to what possible TB symptoms are, or community outreach could assist in getting patients into care more quickly and reducing the economic burden of TB on patients and households.
Incentives for health workers in remote and conflict affected areas: Outcomes and challenges- A case study from Chhattisgarh, India

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ABSTRACT

Background: The Government of Chhattisgarh and National Rural Health Mission (NRHM) launched the Chhattisgarh Rural Medical Corps (CRMC) in 2009 to address the acute shortages of health workers in underserved remote and conflict affected areas. CRMC has made provisions like financial incentives, residential accommodation, life insurance and extra marks during admission in Post Graduation to eligible doctors for attraction and retention of health workers i.e. doctors, staff nurses, Auxiliary Nurse Midwives (ANMs) and Rural Medical Assistants (RMAs) in underserved areas. Methods: We used both qualitative and quantitative research. Three districts i.e. Gariyaband, Jashpur and Kanker which have normal, difficult and inaccessible areas are selected based on purposive sampling method. Key Informants Interviews are conducted to gain perspectives on issues pertaining to CRMC. Respondents comprised of CRMC beneficiaries, non CRMC beneficiaries, district and state government officials. Results: CRMC has made positive outcome as 1319 health workers' including doctors has joined service in 2010-11 reducing the vacancy of doctors from 90% to 45%. Scope of CRMC was primarily limited to payment of monthly financial incentives apart from the monthly salary to staffs for working in CRMC areas. Fund utilization rate of CRMC has increased (i.e. 27% in 2009-10 to 98% in 2011-12) though delays and irregularities in incentives' payment are observed. Majority of staffs lack awareness about CRMC during job application. Ambiguity in CRMC guidelines on linking payment of incentive to staffs and facility performance overlooking the staff's work-load and facilities' functionality had demotivated staffs. Conclusion: A CRMC cell having dedicated staffs would minimize the implementation loopholes. Clarity of CRMC guidelines, prompt grievance redressal, standardizing performance management system and wide publicity of CRMC benefits are likely to improve staff attraction and retention.
Social participation to realize the right to health: A comparative case study of rights-based participation in Health Systems

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ABSTRACT

Background: Community participation is crucial to realising the human right to health. It is a means of engaging with policymakers in setting the agenda, developing and implementing health policies, and creating accountability for policy effectiveness. However, many health systems have not established the structures necessary to promote effective participation. Enabling and sustaining effective participation involves a dynamic and purposeful interaction between government, health care workers, and the communities they serve, allowing for sustainable health services that address local needs. Methods: This comparative case study assesses the obstacles to social participation in progressively realising the human right to health, examining the structures for participation in health systems in South Africa, Guatemala, Uganda, and the United States. Using semi-structured interviews to examine participatory structures recently developed, each case study employs a common questionnaire and conceptual framework and examines participatory spaces in order to analyse the enablers and impediments to meaningful participation in health systems. Results: Policymakers have worked recently to codify structures for community participation in health systems. Although these policies have resulted in a formal system for participation, many policy actors have struggled to implement community participation in practice. Examining multiple dimensions of power ‘in terms of the spaces, levels and forms of power’ illustrates the difficulties of transformative change aimed at realigning power through participation. Discussion and Conclusions: Institutions must be in place to enable effective participation for all, but the specific mechanisms must be context specific and reflect local configurations of power. Attempts to promote people-centred health systems have not adequately addressed the underlying social and political factors crucial to achieving effective participation. This study recommends that policymakers address issues of power in participatory spaces to assure the progressive realisation of the right to health.
Inequities in dietary intake of the urban poor in Bangladesh

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ABSTRACT

Background: Aggregate analysis of dietary intake in Bangladesh suggests urban residents are better off than those in rural areas. In the context of rapid urbanization and the influx of rural migrants into urban slums, a disaggregated approach is necessary. There are concerns that the diet and food security of the urban poor is even more vulnerable than rural residents due to variations in food prices and the fragility of urban livelihoods. This study aimed to explore the extent of inequities in dietary intake comparing the poorest urban quintile with other urban residents and the poorest rural quintile. Methods: Secondary analysis was performed on data from the Household Income and Expenditure Survey (HIES) 2011. Household income quintiles (spatially-adjusted) for urban and rural areas were analyzed separately. T-tests and logistic regression analysis were used to explore household-level consumption of selected dietary components. Findings: In the urban population, those in the poorest quintile consumed significantly fewer calories, less protein, less vegetables and less fruit than their more affluent neighbours (all p<0.05). Relative to the rural poor, the urban poor consumed significantly fewer calories and vegetables (p<0.05) but there was no difference in the amount of protein or fruit consumed. Urban poor households were significantly less likely to meet minimum daily requirements relative to rural poor households for calories (OR 0.63, p<0.05), protein (OR 0.74, p<0.05), vitamin B1 (OR 0.43, p<0.05), vitamin B2 (OR 0.53, p<0.05). However, urban poor residents were significantly more likely to consume sufficient calcium (OR 1.44, p<0.05). Discussion and conclusion: The poorest urban residents have a significantly worse diet relative to more affluent urban residents and to the poorest rural residents. This neglected issue deserves urgent attention.
Achieving equity in skilled birth attendance in Malawi

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ABSTRACT

Background Achieving equity in skilled birth attendance (SBA) has been a priority for attainment of the maternal health MDG, while health equity is an emerging theme for the post-2015 agenda. Malawi has made impressive progress in providing equitable SBA. Between 2006 and 2010, SBA increased from 54% to 71% (and from 50% to 69% in rural areas); the wealth equity gap narrowed from 34% to 26%. We identify leading practices and enabling factors that have contributed these improvements. Methods Data for the case study was collected through a desk review and key informant interviews in October 2012. We used triangulation methods to ensure our data and analysis were robust. Results The following leading practices and enabling factors were found to have contributed to improved equity in SBA. Leading practices: -Community mobilization and awareness: health surveillance assistants working with village committees to encourage women to use facility-based SBA; -Emergency human resource programme: recruitment and deployment of midwives in rural areas; -Public-private partnerships: private providers providing SBA in rural areas. Enabling factors: -Policy environment: an essential health package (EHP), available free of charge, targeting poor and vulnerable populations; -Sector-wide approach: coordinated, comprehensive programme to deliver the EHP; -Decentralization: districts adopt a systematic approach to SBA based on district needs, including working with the private sectors; -National 'road map' for maternal and newborn health with a costed five-year implementation plan. Discussion and conclusions The conceptual framework for this study drew upon the analytical domains of the Tanahashi model and included availability coverage, accessibility coverage, acceptability coverage, contact coverage and effective coverage. It also took account of WHO's building blocks of health systems and the primary health care priorities underpinning the Ouagadougou Declaration. The findings of this study could be useful for other low-income countries.
Access to medicines in Brazil: Policies and strategies from 2002 to 2013

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ABSTRACT

Background: Brazil is a federation containing 26 states divided in 5570 municipalities and a federal district. The health system in Brazil is decentralized and, under the umbrella of the federal guidance, specific policies are implemented at state and municipality level. The aim of this paper is to identify and describe key medicines policies at federal, state and municipal level in Brazil. Methods: We performed a literature review in the Virtual Library of Public Health as well as manual search of the state's web sites for medicines provision policies in course between 2002 and 2013. The screening and data extraction processes were done in pairs and blinded. The final decision was made by consensus. Results: From 162 references and 27 state's web site searched, we included 22 references regarding medicines provision policies at federal and state level. Most of them target policies at federal level, being only 2 references targeting state programs. The references addressing the federal level focus on the free of charge access to medicines, discussing, mainly, government's expenditure, medicines' access through justice requirements, and local pharmaceutical services evaluations. Discussion/conclusions: Brazilian access to medicines provision policies is complex and diversified. To guarantee the Brazilian constitutional right to medicines, the federal government has implemented different kinds of mechanisms; including 'Farmecia Popular' Program (FPP) and its expenditure on those mechanisms have been growing throughout the time. However, it is interesting that the demand for medicines through Justice have been growing, suggesting that these policies might not be effective. This subject has been extremely debated, being the theme of several articles and thesis. Additionally, as Brazil's Health System is decentralized, some state's initiatives have emerged. To know this scenario is essential to understand in which context the FPP initiated and developed along the years.
Benchmarking continuity of care in people-centred health systems: Evidence from newly diagnosed diabetes mellitus patients

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ABSTRACT

Background: Improving the quality and value of chronic disease management program is of critical importance when building people-centred health systems. To improve quality of care for the diabetic patients, Taiwan National Health Insurance Administration introduced a Pay-for-Performance (P4P) scheme in 2001, of which continuity of care (COC) was an important working mechanism by design. This study aims to discern the independent effects of P4P and COC on health expenditure and further to disentangle the impacts of institutional continuity of care (ICOC) and the patients' provider-switching behavior on the treatment cost incurred. Methods: The study examined a cohort of 46,827 newly diagnosed diabetes mellitus patients from 2002 to 2009. The ICOC index considered visits to all institutions and calculated the degree of variation in number of visits. An index variable was also constructed to monitor patients' provider-switching behavior from year to year. The patients' participation in P4P program was analyzed with a fixed-effect logit model using lagged individual characteristics, provider characteristics, and policy variables. Health expenditure was analyzed with a fixed-effect OLS model using lagged individual and provider characteristics, ICOC, whether the patient has switched ICOC provider from year to year and estimated P4P participation. Results: The institutional effects appeared to be the most significant factors affecting P4P participation. Both P4P and ICOC were positively and significantly associated with outpatient expenditure, but only ICOC showed a significantly negative association with inpatient expenditure. Whether the patient changed his/her institutional COC provider from year to year explained a substantial increase in treatment cost. Discussion/Conclusions: Findings indicated that the P4P design promoting ICOC seems to be effective in reducing health expenditure from a longitudinal perspective. Furthermore, quality and values of the P4P program can be assured through better coordination of care and incentives to enhance ICOC should be provided in people-centred health systems.
No one should be left behind': An analysis of political commitments to reducing urban health inequities in Lagos, Nigeria

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ABSTRACT

In March 2012, the government of Lagos launched the Lagos Investment Case ‘Addressing Health Inequities in Lagos State. The Investment Case triggered a political momentum around the challenge of Lagos rapid urbanisation and the urgent need to invest in its population by addressing health inequities, particularly as they affect populations settled in dense slum areas. The Lagos State government committed to reversing these following three sets of policy recommendations that emerged from the Lagos Investment Case: (i) Bring health services closer to communities through an expansion of the coverage community health extension workers particularly in slums areas, a strengthened partnership with private health service providers, the removal of financial barriers with the establishment of a State Health Insurance Scheme, the removal of user fees and cash transfer programmes. (ii) Bring communities closer to health by establishing a vital partnership with the people of Lagos with the view of ensuring that the most underserved are able to take ownership of the health system and ensure that it works for them. (iii) Ensure the quality of essential health services by aligning Lagos health services with international protocol, monitor progress towards the removal of bottlenecks at decentralized levels, and coordinating action with other cross-cutting areas, notably those pertaining to nutrition, water improvement, sanitation, hygiene, key family practices, and child protection. The paper describes the investment case process that resulted in the creation of a political momentum for reducing urban health inequities in Lagos State. We review the policy process that made the mobilisation of key stakeholders and a consensus on strategies to reduce health inequities possible. We then assess achievements to date and discuss challenges faced in operationalising a pro-poor & people-centred urban health approach, in particular those related to revitalising a primary health care system in the underserved slums of Lagos.
The poverty penalty in health: Health-seeking behavior of the working poor and opportunities for private sector health care

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ABSTRACT

Background: The poverty penalty refers to the relatively higher cost shouldered by the poor, when compared to the non-poor, in their participation in certain markets. These markets include basic human commodities and services, including health. We demonstrate this phenomenon through the health-seeking patterns exhibited by the working poor in twelve Counties in Kenya. Methods: Data were collected qualitatively through in-depth interviews, focus group and open forum discussions with private sector stakeholders and working poor consumers. Results: Findings show that for one illness episode, seeking health care sequentially progresses from self-medication, herbal/traditional care, public health facility to private health facility. In severe cases, the pattern skips the public facility direct to the private facility. The costs to the poor include payment for services and commodities at each stage. At the end of the illness episode, they pay more than they would have if they went straight to a public or private health facility. The main reason given by the working poor for seeking care in this pattern is lack of money to pay for services in public and private facilities. Following the health-seeking patterns herein, the reality is that the monetary cost of one illness episode is more than the cost of the same if care is directly sought at the public and/or private health facility. Also, there are non-monetary costs such as increase in illness severity, length of illness episode and economic losses due to extended illness. Discussion/Conclusion: The health-seeking pattern demonstrated here shows a need to reduce the overall cost of health care for the poor. It also shows an opportunity for the private sector to reduce the poverty penalty for the working poor by providing services that are targeted, affordable, accessible and of good quality in order to reduce the eventual high costs incurred through this health-seeking pattern.
Conceptualising health teams in decentralised health systems -
A case of district based clinical specialist teams in
South Africa.

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ABSTRACT

Reforms geared towards the decentralisation of health system management functions and the delivery of
primary health care (PHC) have been noted in many low and middle income countries. However, how districts
are conceived of and operate vary in different contexts. The District based Clinical Specialist Teams (DCSTs)
have recently been introduced in South Africa to improve efficiency, equity and governance within a currently
under-performing health system. Whilst the district health system (DHS) in South Africa still faces a number of
barriers to a successful decentralisation; it is anticipated that the introduction of new agents - the DCSTs, may
positively impact on the existing DHS status quo, the organizational structure and relationships within the
system. As the implementation process is still in its early phase, there is a need to develop a conceptual
framework that could outline how the DCSTs' teamwork processes would be conceived by DCSTs members
and other actors within the DHS that will support their role and functioning. Yet, little is known about how
relationships between the DCSTs and existing service providers should be conceived in the district or the
extent of the DCSTs role in the reorganization and management of PHC delivery in South Africa. What
framework should guide actors in the process of implementation and how should roles and responsibilities be
shared among actors? Purpose: To develop a preliminary conceptual framework that could highlight team
engagements in decentralised DHS. Focus: Through a literature and document review; the proposed roles
and functioning of the DCSTs in the DHS based on the South African PHC reengineering policy framework
will be used to map key criteria for understanding team engagements in different contexts. Significance: To
stimulate DHS actors' perceptions about roles and relationships and how functional team engagements in
different contexts can be conceived and modelled at the district level.
Health worker incentives in post-crisis Zimbabwe

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ABSTRACT

Background Health worker choices are arguably the most critical factor affecting the performance of a health system. In post-crisis settings, where health systems and health worker livelihoods have been disrupted, the challenges facing the establishment of the right incentive environment are particularly important, and the contextual dynamics around them especially important to understand and incorporate sensitively into policy measures. The study examines how incentive environments have evolved during and after the crisis in Zimbabwe, what influenced the trajectory, what have been the reform objectives and mechanisms, and what are their intended and unintended effects with regards to access and quality. Methods The research uses mixed methods, including document review; key informant interviews; career histories of health workers and a health worker survey. Results In the four sectors studied (public, mission, municipal and private) remuneration emerged as the key attribute impacting on health worker attraction, retention, distribution and performance. Municipal providers offer a robust incentive package which translates into a stable and well distributed workforce. The private sector has a lean health work force and attracts disaffected public sector health staff for locum work due to highly attractive rates. The public and mission sectors offer low salaries and the targeted retention allowance which in the short term has seen improvements in health worker attraction and retention. Conclusion Health worker incentive policies require an integrated approach to ensure that access to and quality of services is not affected. Migration of skilled and experienced health workers from sectors offering poor incentives to those that have superior incentives leads to maldistribution of health workers. Skilled and experienced health workers are concentrated in low level health facilities with superior incentives that refer complicated cases to large public sector facilities with less skilled and experienced staff.
Dying for affordable maternal services: Study on social determinants of maternal mortality in Western Kenya

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ABSTRACT

Background: Universal Health Coverage become increasingly significant for post MDGs agenda to articulate accessible and affordable health services to those who are most demanding. In this study, the full pictures of maternal mortality were holistically analyzed by social determinants and promote noble challenges in achieving Universal Health Coverage. Methods: Semi-structured interviews were conducted with the family and kinship members of all the maternal death cases in two districts of Nyanza province, Kenya from August 2011 to September 2012. Results: All of 10 mortality cases were identified and reviewed by this study. Seven cases were less than 25 years old (average 23.3) and six cases were single or widowed. Nine cases were from families of low socio-economic status (monthly income less than $25). Five cases were delayed in deciding to seek care because of lack of knowledge or financial problems, seven were delayed in reaching care in time due to poor road conditions or lack of transportation, and five were delayed in receiving adequate care because the poor health service quality. Four experienced the delayed timing of referral to higher level of health facilities and more than two delays were combined in 8 cases. In six cases, the main decision maker was male while a person whom she talked to when she had health problems was all female, such as mother-in-law or other relatives. Conclusion: The challenges in achieving Universal Health Coverage could be diverse and needs to be holistic approach beyond health sector. However this study stresses the importance of economic and cultural barriers, which hamper the indigent initial access to the health services. Community-participatory interview may be powerful tool to advocate policy makers the strategies of challenges in Universal Health Coverage.
How can health systems address inequalities across populations: A case-study from the United Arab Emirates (UAE)

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ABSTRACT

Background: The United Arab Emirates (UAE) is a Middle-Eastern country in the Arabian Gulf where only an estimated 10-15 percent of the population consists of citizens. The rest are migrants, who are predominately low-income male laborers from South and Southeast Asia. These migrants who temporarily live in the UAE have a distinct health profile from their citizen counterparts, which has yet to be systematically quantified.

Significance: To illustrate how a burden of disease study can be utilized as an important methodological tool for health systems research to systematically quantify and address health inequalities across populations.

Methods: World Health Organization and Global Burden of Disease Study protocols were followed to conduct a national burden of disease analysis for the UAE. Local mortality data were used. Years of Life Lost (YLLs) were calculated by age, sex and nationality. Results: In 2010 an estimated 291,834 YLLs were lost due to disease and injury conditions in the UAE. Migrants were responsible for 73% of this burden, despite accounting for 84% of the population. The leading causes of YLL loss for migrants were motor vehicle crashes, ischemic heart disease and other circulatory disorders. When examining mortality differentials, migrants experience more fatal injuries like suicides and falls than nationals. Conclusion: This study has highlighted the higher burden of fatal injuries like suicides and falls among migrants. It also shows that given their size, migrants account for a smaller portion of the mortality burden than nationals. Such a difference may be attributed in part to governmental policies regarding migration and differentials in healthcare utilization. These findings have important policy and research implications for the UAE and suggest that migrant-focused health policies and interventions are warranted. This study illustrates how health inequalities may be quantified and better understood from a health systems perspective through burden of disease studies.
Gendered health care coping in northern Uganda: What are the gender and equity considerations in post conflict health system strengthening?

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ABSTRACT

Background: Health and health care are a right, yet they continue to elude many in conflict and post conflict situations. While the gendered nature of war and its aftermath are well known, humanitarian and post conflict health system reconstruction continues to focus on infrastructural development. The assumption is that once the facilities exist, anyone should be able to access health care equally and equitably. This ignores the multiple challenges and costs women, men, girls and boys have to negotiate when required medicines are not available or when they are referred for costly investigations. This research documents the gendered nature of household coping with health care costs in Gulu District, northern Uganda.

Methods: Research was conducted in Gulu District using multi-methods combining a survey of 498 randomly selected households; life history interviews with community members, and key informant interviews with health providers and opinion leaders, all selected purposively. Quantitative data was conducted using STATA and Excel while qualitative data was analysed thematically using Atlas ti. Results: Our findings demonstrate that gender and age interplay to mediate people’s ability to access health care in a post conflict setting. Specifically, the gender and age of the household head (being female and older) were key factors in post conflict household livelihood strategies, affecting health and well being, as well as strategies and ability to cope with emerging health care costs. Discussion/ Conclusion: It is hoped that this view from the field will stimulate debate on how we should rethink health system strengthening in general and after conflict in particular to facilitate equitable health care access to the poor. There is need to focus beyond infrastructural development to also provide policies and processes to enable equitable access to health services through mainstreaming gender in post conflict reconstruction.
Inequality and access of basic public health services for migrates in a city of China

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ABSTRACT

Background As a stress of the new health reform, improving the equality for Basic Public Health Services (BPHS) proposed by Chinese central government in 2009. The policies advanced to ensure the access for all citizen gaining basic public health services covering in the package, including migrate population over 236 million. How is the progress? The study identify the access of BPHS for migrates and the association of social-demographic characteristics.

Methods A cross-sectional survey used and sample choose in two districts of a municipalities, and 976 adult migrates (age>18) were eligible for this study. Participates completed a questionnaire on access of health care and health literacy. Multi-linear regression was used.

Results Overall, 45.9% of the subject reported to not gain BPHS and 25.8% said ‘do not know it’ during the previous year, only 16.5% had health education and 3.8% with health records. Even they expressed the expectation and demands but they not gained expected access to BPHS, and lower than the citizens. The access ratios were independently associated with the employment unit, gender and household per capita income, as well as level of health literacy and the awareness to seeking health care.

Conclusions It present a significant inequality of BPHS for migrates in a city and the gap of access among migrates and permanent residents. The migrates are key priority groups for improving the equitable access and achieve the goal of BPHS. Policies aimed at reducing such inequality gaps should be developed, and accompanied by more efforts to improve people-centred health system greater responsive and more justice as well enhance the role of employment unit in health education. The strategies improving inequality for migrates also indispensable essential on increasing their health literacy and promoting the awareness for seeking care and active participation. Key word: inequality, access, basic public health services, migrates
Understanding 'privacy' in Emergency Obstetric and Newborn Care (EmONC) Facilities from patients' perspective: A qualitative investigation

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ABSTRACT

Introduction: People in most cultures bear strong sense of privacy regarding their bodily exposure to others. Bodily integrity focuses on the magnitude of sovereignty and self-determination of people over their individual bodies. The Commonwealth Countries League (CCL) Working Conference on Women's Rights as Human Rights said, 'Bodily integrity unifies women and that no woman can say that it does not apply to her.' Methods and materials: Observations of cases who came for maternal complications at certain corners of facilities providing EmONC services (41) and exit interviews with family members (68) were carried out in different layers of health facilities in four hard-to-reach districts of Bangladesh. Result: Community people mentioned 'privacy' as one of the main reason for preferring home deliveries. There is huge social stigma surrounding hospital delivery which exposes women's body to unknown people, some of whom are male. Our observations suggested that privacy was hardly maintained at different corners of EmONC facilities such as OT room, post-operative room, labor room and maternity ward. Women mentioned presence and easy access of male providers who were often support staff in these corners. We also observed male support staff often changing cloths of delivering women lacking sensitivity surrounding this issue. Maternity wards were found full with male attendants and support staffs that discomfort new mothers to breastfeed, change clothes, go to toilet and so on and no option (i.e. curtain) was available to isolate the beds. These situations were very shocking and disgusting to women. Conclusion: All providers should go through awareness session regarding the privacy of the patients. Administrative steps should be taken so that providers take consent and consult with patients regarding delivery process. Health facilities should be equipped with adequate curtain, female manpower and proper management system to restrict people’s entrance at maternal health related areas.
Predictors of disrespectful and abusive behaviors to pregnant women during facility-based childbirth in Tanzania

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ABSTRACT

Background: There is growing body of evidence that suggests disrespectful and abusive care (D&A) during childbirth is a significant barrier to quality maternal health services and outcomes. However, little has been documented on factors associated with D&A in resource-limited settings. Methods: We conducted a cross-sectional survey of 2,000 women shortly after delivery in a large urban hospital in Tanzania, to determine prevalence and predictors of D&A during childbirth. D&A was assessed in seven dimensions i.e. physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Results: Mean age of study participants was 26 years. Fifteen percent of women interviewed reported experiencing at least one form of D&A during childbirth. In bivariate regression, women with lower education (p <0.01) and lower wealth quintile (p =0.02) were significantly less likely to report D&A. However, other factors assessed (i.e. age, marital status, occupational status, HIV status, number of previous births, number of antenatal visits, time of delivery, and type of provider who conducted delivery) were not significantly associated with overall D&A. In multivariable regression, with age, education level and wealth quintile, women with incomplete and completed primary education were 68% and 26% respectively, less likely to report D&A compared to secondary or higher education. (OR= 0.32, 95%CI; 0.07-1.36 and 0. 74, 95%CI; 0.56-0.99, respectively). However, within individual D&A dimensions, significant relationships were also observed between: occupation status and physical abuse; HIV status and non-consented care; education and non-confidential care; wealth and non-dignified care; and wealth and abandonment of care. Conclusion: While factors such as education, wealth and employment were associated with higher likelihood of reporting D&A, this may also suggest that most vulnerable women may have normalized these behaviors. More studies are needed to further delineate the complex and multifaceted nature of D&A.
Measuring and understanding motivation among health workers in rural health facilities in India-a model based approach

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ABSTRACT

Background: Motivated human resource is key to improving health system performance and retention of health workers. There is little literature on measuring motivation of health workers in developing countries. The purpose of this study was to measure and identify important aspects of health workers motivation in North India. Methodology: The study interviewed randomly selected 62 health workers in 18 sub-centres of Shahzadpur Block, District Ambala of Haryana, India. Results: Job experience and training in the past 12 months was found to be significantly associated with motivation. Excessive workload, poor job security, less career opportunities and poor health were individual level determinants of de-motivation, whereas poor family support and poor supportive supervision were environmental factors breeding poor motivation. Conclusion: Non-financial motivators such as interpersonal relations, family support and skill and career development opportunities warrant more attention. Quality need-based training is essential to maintain high levels of motivation.
Social protection in health in Burkina Faso: analysis of a solidarity program to join the poorest to a health insurance.

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ABSTRACT

Objective In 2012, the Réseau d'appui aux Mutuelles de Santé (RAMS) and the Ministry of Social Action and National Solidarity (MSANS) organized a national program to improve access to health services for poor households. Government provided a grant to RAMS to affiliate 1,200 poor households (4,500 beneficiaries) to mutual health organization. Our research analyzes the emergence, formulation and implementation of the program. Method It is a single case study based on several analyses on three levels in the program process. Interviews (n = 55) were conducted with four categories of involved actors. The 'framework analysis' approach guided data analysis. Results The establishment of universal health insurance (UHI) was the opportunity for the emergence of the program. UHI provides a legal health insurance scheme for government workers and a voluntary scheme based on MHO for informal and agricultural sector. There is a challenge on the issue of indigent (identification, affiliation to MHO). In order to have knowledge from contextual experience, the MSANS provides a subsidy to RAMS to affiliate poor households to MHO. The formulation of the program profited more to MHO than to poor households. Beneficiaries were not exempt from co-payments. Co-payment is maintained because of MHO operation principle and the fear to pay substantial costs of benefits that can be detrimental to the MHO financial capacity. The strategy for beneficiaries selection by MSANS social workers has shortcomings. A lack of collaboration and communication is found in the implementation. Conclusion Analysis of the emergence shows that actors recognize the importance of contextual evidence to improve their practices and make interventions focused on the needs of people. However, the proposed solutions benefit more to MHO than poor. The selection process of poor households was passive and privileged people who have already used social services to the detriment of remote villages residents.
Post-abortion contraception services: Knowledge, Attitudes and Practices (KAP) among service providers in China

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ABSTRACT

Objectives: China has a high abortion rate with 19.0\%-57.9\% repeat-abortions among different populations. Post abortion contraception (PAC) is considered as an effective way of reducing the rates of unintended pregnancy and repeat-abortions. Service providers (SPs) provide PAC services to abortion users play a crucial role in this system. We conducted two surveys in China aiming at identifying the characteristics of the SPs, determining their KAP in PAC services. Methods: Two cross-sectional surveys were conducted in 2009 and 2013 respectively. The methods used in the two time periods were similar: abortion SPs in participating hospitals were invited to fill out a structured questionnaire voluntarily and anonymously. Twenty-four hospitals in 2009 and 90 hospitals in 2013 participated to the studies. Results: Total of 654 respondents in 2009 and 593 in 2013 were included in the analysis. The characteristics of the participants were similar, among them, 96\% females with an average age of 38.2 years (SD 9.6). Most of them were experienced professionals with a mean seniority of 15.3 years (SD 9.8). Almost all participants (95\%) had positive attitudes and intentions on providing PAC counseling to clients. However, 20\% respondents have never or only occasionally provided PAC service to women and 45\% never to the male partners. 50\%-80\% SPs failed knowledge tests on use of contraceptives and on PAC services. Perceived barriers for providing effective PAC services include lack of human resources (22\% SPs work overload in 2009 and 60\% in 2013), no/limited access to technical guidelines and appropriate education/counseling materials (30\%), inadequate consulting environment and consulting skills (21\%), and lack of policy and management supports (68\%). Conclusions: Abortion service providers have positive attitudes and intentions on providing PAC services. There is a need for improvement of knowledge, appropriate access to technical guidelines, as well as support from policy and management boards.
Horizontal inequity in public healthcare service utilization for non-communicable diseases in urban Vietnam

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ABSTRACT

Background Universal health coverage (UHC) aims to ensure that all people can access to healthcare services at affordable cost. In 2008, Vietnam approved the law on Social Health Insurance (SHI) to create a national SHI program, and in 2012 developed a Master Plan and roadmap towards UHC in the period 2012-2015 and 2020. However, SHI may not be a panacea to achieve UHC, especially when individual facing NCDs. Methods A cross-sectional survey of 1211 randomly selected households in slum and non-slum areas was carried out in four urban districts of Hanoi city in 2013. The information of 3736 individuals 15 years old and more was used for the analysis. Respondents were asked if the individual's self-report on healthcare use during last 12 months, including information about sex, age and self-reported NCDs. We accessed the degree of inequity in utilization of public healthcare service. Concentration indices of healthcare use (CM) and healthcare needs (CN) were obtained. The CNs was constructed by using a probit regression of the individual's utilization of public healthcare services, controlling for age, sex and self-reported of NCDs for each individual. CMs were decomposed to identify factors contributing to inequalities in healthcare use. Results and conclusions The proportion of healthcare utilization in the slum and non-slum areas was 21.4% and 26.9% in the last 12 months, respectively. The horizontal inequity in healthcare utilization in favor of the rich was observed in the slum areas, whereas horizontal equity was achieved among the non-slum areas. In the slum areas, decomposition of CM demonstrated that having self-reported NCDs was a contributor to widening inequality, while having SHI and higher socioeconomic status were contributors to reducing inequality. Our results suggest that to achieve horizontal equity in utilization in public healthcare services, targeted policy attention should pay more on preventive interventions for NCDs, focusing more on the poor in the slum areas.
Universal health coverage in 'One ASEAN': are migrants included?

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ABSTRACT

As the Association of South East Asian Nations (ASEAN) is getting ready towards full economic integration by 2015, the cross-border flow of skilled labor in particular and of citizens in general is expected to further intensify in the coming years. While the regional bloc's ten member countries has already signed the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers, the health rights of migrants still need to be highlighted and addressed, especially with ongoing reforms towards achieving universal health coverage (UHC) in most ASEAN countries. This paper seeks to examine the inclusion of migrants in the UHC schemes of five ASEAN countries - Indonesia, Malaysia, Philippines, Singapore and Thailand - which exhibit diverse migration profiles and currently undergo varying stages of UHC development. Current migration trends and policies, as well as ongoing UHC developments and their migrant health-related features were reviewed. In general, all five countries, whether receiving or sending, have some scheme that covers migrants to varying extents. Thailand allows undocumented migrants to opt into the insurance pool, while Malaysia and Singapore should include migrants in their government-run schemes. The Philippines provides portable yet limited benefit packages, while Indonesia must work toward strengthening the health insurance component of its compulsory migrant insurance. Overall, ASEAN countries will still have to ensure genuine inclusion of undocumented migrants in UHC; however, this will require strong political decisions from agencies outside the health sector that govern migration and labor policies. Furthermore, they should continue to engage in multilateral and bilateral dialogue as they redefine UHC beyond the basis of citizenship. In conclusion, by enhancing migrant coverage, ASEAN countries can make UHC systems truly 'universal.' Moreover, it is in ASEAN's best interest to protect the health of migrants as it pursues the regional path towards collective social progress and economic prosperity. Key words: migrant health, migrant labor, ASEAN, universal health coverage
Health insurance coverage inequality in post-Jamkesmas Indonesia

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ABSTRACT

Background: Jamkesmas, a voluntary health insurance scheme for the poor and near-poor introduced in 2004, expanded insurance coverage to nearly one-third of the Indonesian population. Little is known about how equitably health insurance coverage is distributed after Jamkesmas was introduced. Methods: I used data from the 2012 Indonesia Demographic and Health Surveys to compute raw concentration indices (CM) for insurance coverage for Indonesia as a whole and by urban/rural area within each province. I then fitted a logit model to determine factors associated with having insurance coverage. Results: The overall CM for insurance coverage was 0.05 (p<0.001), indicating slightly higher coverage among wealthier individuals. For urban areas, inequity exists in 15 of 33 provinces, including Jakarta (CM: 0.24, p<0.001). Inequity was highest in urban North Sulawesi (CM: 0.26, p<0.001) and lowest in urban Riau Islands (CM: 0.09, p=0.03). For rural areas, inequity exists in 7 of 32 provinces, with CM ranging from 0.45 (p<0.001) in Papua to 0.09 (p=0.02) in Southeast Sulawesi. Results from the logit model suggest that individuals in the poorer, middle, and richer wealth quintiles were significantly less likely to have insurance than those in the lowest wealth quintile (marginal effects (ME): -0.05, -0.07, -0.10, respectively, all p-values<0.05), as were those who live in rural areas (ME: -0.08, p<0.001). By contrast, higher education (of respondent, spouse) and professional/managerial occupation (also of respondent, spouse), were associated with higher likelihood of coverage. Conclusions: Inequity in insurance coverage is relatively low overall, but disaggregated analysis by province and urban/rural area reveals wide variation in the level of inequity across the country. These findings imply that some segments of the population, namely rural-dwellers and those in the middle wealth quintiles, are potentially still excluded from accessing formal medical care where cost is often a barrier to health service use.
Understanding responsiveness of human resource for health:  
A review of literature

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ABSTRACT

Background The concept of responsiveness came to discussion during and after the publication of WHR2000. It proposed a framework, where responsiveness was one of the goals of health systems. The report used the term in context of 'health system'. Later WHR2006 used this term in context of HRH (HRH performance domains: availability, productivity, competency, responsiveness). Purpose of this review was to define, and identify domains of 'HRH responsiveness'. Methods PubMed search with following term was done: (((('Health Manpower'[Mesh]) AND 'Patient Satisfaction'[Mesh]) OR 'Attitude of Health Personnel'[Mesh]) OR 'Healthcare Disparities'[Mesh]) OR 'Professional-Patient Relations'[Mesh] AND responsiveness. This yielded 171 articles. After screening the items and consulting the experts a master-list of 52 items was generated. Result We classified the literature into 1) generic works (non specific to the country, professional setting or professional groups), 2) responsiveness works done either in a country or particular setting or among specific group, 3) literature from relevant fields, e.g. patient satisfaction, quality of care, and 4) a table was created for the 'HRH responsiveness domains' deriving from previous groups. Some identified domains are: respect for dignity, confidentiality, autonomy, clear communication, attention, effective care, access to care, medical ethics, work process, gender sensitivity, use of household language, clean appearance of staff. Following definition has been adopted, 'HRH responsiveness is not what is expected by people or clients from the HRH; nor is it what they (the HRH) are capable of doing given the resources and time constraints. Rather this is the minimum set of standard 'non-health' actions, what they actually should do in order to meet the legitimate expectations of the service seekers'. Discussion and Conclusion This literature review contributed to further research on understanding HRH responsiveness in a particular setting, by supplying a-priori themes for qualitative analysis. This also helped in developing an HRH responsiveness scale by supplying potential scale items.
Income related inequalities in new cooperative medical scheme: a five-year empirical study of Junan in China

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ABSTRACT

Background The Chinese New Cooperative Medical Scheme (NCMS) was launched in 2003 aiming at protecting the poor in rural areas from high health expenditures and improving access to health services. The income related inequality in NCMS is a debating and concerning policy issue. The purpose of this study is to analyze the degree and changes of income related inequalities in both inpatient and outpatient services among NCMS enrollees from 2007 to 2011. Data and methods Data was extracted from NCMS information system of Junan County in Shandong province from 2007 to 2011. The study targeted all NCMS enrollees in Junan, 726850 registered in 2011. Detailed information included demographic data (age, sex, etc.), inpatient and outpatient data (visits/admissions, length of stay (LOS), total expenses, reimbursement and self-payments) in each year. Descriptive analysis and standardized concentration index (CI*) were employed to examine the equalities in both inpatient and outpatient care. Main Results For inpatient care, the benefit rate CI* was positive (pro-rich) and increased from 2007 to 2011 while for outpatient care was negative (pro-poor) and a decreasing pattern was observed. For outpatient visits and expenses, the CI* changed from a positive sign in 2007 to a negative sign in 2011 with some fluctuations. The pro-rich inequality exacerbated for admissions while alleviated for LOS and total inpatient expenses. The pro-rich inequality for inpatient reimbursement aggravated from 2007 to 2010 and alleviated from 2010 to 2011. The richer enrollees needed to afford more self-payments for inpatient services while the inequality for outpatient self-payments changed from pro-rich in 2007 to pro-poor in 2011. Conclusions In NCMS, the pro-rich inequality dominated for inpatient care while a pro-poor advantage was shown for outpatient care from 2007 to 2011. The extent of pro-rich inequality in LOS, inpatient expenses and inpatient reimbursement increased from 2007 to 2009, but recently between 2010 and 2011 showed a change favoring the poor.
Maternal and child health handbook as the tool for universal MNCH coverage in Vietnam

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ABSTRACT

[Background] In Vietnam, multiple maternal and/or child health home-based records have been implemented in several provinces in a fragmented manner. To address this reality, the Ministry of Health and JICA have been attempting to standardize the Maternal and Child Health Handbook (MCHHB) for nationwide scaling-up, through the field testing in four provinces (Dien Bien, Hoa Binh, Thanh Hoa and An Giang), since 2011. Of 413,922 pregnant women and mothers registered in the four provinces in 2012-2013, 331,717 (80.1%) received the MCHHBs in the four provinces. [Methods] To estimate effectiveness of the MCHHB, the cross-sectional data were collected from pregnant women, mothers/caregivers and health workers in the four provinces before and after the MCHHB interventions (2011 and 2013). Structured interviews with and observation of pregnant women, mothers/caregivers and health workers were conducted on their knowledge, attitude and practice (KAP). [Results and discussion/conclusions] In 2011 (baseline), 800 pregnant women/mothers with infants and 160 health workers were interviewed and observed. In 2013 (end-line), 810 mothers with children 6-18 months and 420 health workers were interviewed and observed. The proportion of those who correctly listed up all seven danger signs during pregnancy significantly increased from 0.1% to 52.1% among mothers (p<0.00.1) and from 0.6% to 12.4% among health workers (p<0.001). This increase in knowledge coincides with high proportion of mothers who bring the MCHHBs to health facilities (81%) when receiving antenatal care services. The results of three antenatal care visits or more were either fully or partially recorded on 493 (66.3%) of all 744 MCHHBs held by mothers. As the result, the proportion of mothers who had at least three ANC visits slightly increased in all four provinces. The similar improvement was confirmed in KAP on child health among pregnant women, mothers/caregivers and health workers. Thus, the MCHHB has potential for nationwide scaling-up. (299 words)
Regulating for equity? A methodological approach for trans-disciplinary assessment of tensions and interplay between legal, political, administrative and professional priority-setting tools in healthcare

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ABSTRACT

Purpose In any healthcare system, healthcare provision is regulated through implicit and explicit distributive norms, political decisions, administrative procedures and established clinical practice. Various regulatory instruments are at work at the same time; laws, political decision-making processes involving cost-effectiveness and evidence-based assessments, bureaucratic requirements and clinical guidelines. If the overall goal of a healthcare system is to promote equitable healthcare, all implemented regulations that shape clinical practice must work efficiently together in order to reach this goal. To investigate how healthcare systems perform in this respect, we need a method that allows us to identify, juxtapose and evaluate tensions and interplay between different kinds of regulating tools and mechanisms. Focus/content The focus of this presentation is to propose a methodological approach for organizing a large interdisciplinary study on various factors that influence priority setting in Norwegian healthcare. We focus on the field of cardiovascular medicine and pay particular attention to the distributive impact on elderly and socioeconomic disadvantaged patients. Further, the study draws on numerous disciplines, law and human rights, philosophy, sociology, political science, anthropology and medicine. To enable comparison on a common set of premises, the researchers must transcend their discipline specific considerations and establish a common platform of knowledge for the preparation of the particular research designs. The presented method addresses how a base of knowledge can be established, structured, developed and maintained throughout the whole period of research and by joint involvement of all the researchers. We also sketch the substantive content of the platform. Significance This methodological approach supports research that can help healthcare systems promote equitable healthcare and it is applicable to interdisciplinary research in any healthcare system. Target audience The method would be of interest to anyone involved in interdisciplinary healthcare system research, as well as politicians and clinicians.
Gaps in universal health coverage in Malawi: The perspective of rural communities

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ABSTRACT

Background: In sub-Saharan Africa, universal health coverage (UHC) reforms have often adopted a technocratic top-down approach with little attention being paid to the perspective of rural communities. In order to contribute to a health system responsive debate on UHC reforms in Malawi, our study explored how rural communities in Malawi experience and define gaps in the coverage provided by their health care system. Methods: A qualitative cross-sectional study was conducted in Malawi, where an Essential Health Package (EHP) is being implemented for UHC. The data was collected from 12 Focus Group Discussions (FGDs) with community residents and then triangulated with 8 key informant interviews with health care providers in two rural districts. Results: The results showed that the EHP has created a universal sense of entitlements to free health care at the point of use. However, respondents reported uneven distribution of health facilities and poor implementation of public-private service level agreements which has led to geographical inequities in population coverage and financial protection. Rural Malawians therefore reported affordability of medical cost at private facilities and transport cost as the main barriers to universal financial protection. From their perspective, gaps in financial protection are mainly triggered by supply-side access-related barriers in the public health sector such as: shortages of medicines, emergency services, health personnel and facilities; poor attitudes of health workers, distance and transportation difficulties, resulting in perceived poor quality of health services. Conclusions: There is an inter-relationship of UHC gaps in Malawi. This implies that current universal health coverage reforms being advocated for in Malawi need to adopt an integrated approach aimed at simultaneously addressing financial protection gaps in the private sector and access-related gaps in the public sector. Such reforms must therefore be carefully grafted to reflect context-specific UHC needs and the preferences of rural Malawians.
An attempt to address poverty through national Tuberculosis control program in India.

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ABSTRACT

Concept Brief: To identify the synergies between poverty alleviation schemes with national TB* control program and to generate evidence for the TB control program in integration of any of the poverty alleviation schemes with RNTCP*. Background: The linkages between poverty and TB are established historically that poor were two times more likely to have TB, three times less likely to access TB care, four times less likely to complete treatment and many times more likely to incur impoverishing payments for TB care. Recognising the pivotal role of TB control in alleviating poverty, the WHO*-Stop TB Partnership established a sub working group on TB and Poverty, the secretariat for this sub group more recently located in a TB high-burden country- India. Purpose: There is lack of information on service delivery synergies between TB control programme and centrally sponsored poverty alleviation schemes and state specific poverty alleviation programmes aimed at benefitting the poor. Further in-depth analysis and systems/policy/operations research exploring pro-poor initiatives, in particular examining service delivery synergies between existing poverty alleviation schemes and TB control programme is essential and further planning and research on pro-poor TB centric interventions in the country. Project Theme: Linkage of TB-HIV in RNTCP is known. Like if someone is diagnosed with TB, he/she is sent to ICTC for HIV testing. Similarly, if someone is diagnosed with TB and is BPL* or belongs to a tribal / backward area (whatever criteria one chooses), a system should be developed so that RNTCP facilitates his uptake of poverty alleviation schemes in the area. To advocate for the development of above linkages, we'll have to identify 1. What is the uptake of poverty alleviation schemes among eligible TB patients in an area? 2. What is the KAP among programme managers about poverty alleviation scheme in their area? RNTCP*- Revised National Tuberculosis Control Programme, WHO*- World Health Organization, TB*- Tuberculosis.
Evidence on access to medicines for chronic diseases from household surveys in five low- and middle-income countries

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ABSTRACT

Background: The 2011 UN General Assembly Political Declaration on Prevention and Control of Non-Communicable Diseases (NCD) brought NCDs to the global health agenda. Essential medicines are central to treating chronic diseases such as hypertension and diabetes. Our study aimed to quantify access to essential medicines for people with chronic conditions in five low- and middle-income countries and to evaluate how household socio-economic status and perceptions about medicines availability and affordability influence access. Methods: We analyzed data for 1867 individuals with chronic diseases from national surveys (Ghana, Jordan, Kenya, Philippines, Uganda) conducted in 2007-2010 using a standard WHO methodology to measure medicines access and use. We defined individuals as having access to medicines if they (1) reported regularly taking medicine for a diagnosed chronic disease and (2) data collectors found a medicine indicated for that disease in their homes. We used logistic regression models accounting for the clustered survey design to investigate determinants of keeping medicines at home and predictors of access to medicines for chronic diseases. Findings: In each country, less than half of individuals previously diagnosed with a chronic disease had access to medicines for their condition; in Uganda, this proportion was below 20%. Other than reporting a chronic disease, higher household socio-economic level was the most significant predictor of having any medicines available at home. The likelihood of having access to medicines for chronic diseases was higher for those with medicines insurance coverage and lower for those with past history of borrowing money to pay for medicines. Interpretation: Our study documents poor access to essential medicines for chronic conditions in five resource-constrained settings. It highlights the importance of financial risk protection and consumer education in global efforts towards improving the treatment of chronic diseases.
Linking health states to subjective well-being: An empirical study of 5,854 rural residents in China

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ABSTRACT

Background: Measures of subjective well-being (SWB) can be useful in assessing policy interventions in various domains, but the application in healthcare is rare, for the role health states play in individuals' subjective evaluation of quality of life remains indefinite and most research are concerning patients other than the general population. This study was aimed to explore the correlation between health states and SWB of Chinese people and provide reference to the appraisal of China's health reform. Methods: Data derived from a household survey conducted in 2010 with 5,854 rural residents included. SWB was obtained by the open-ended question used in the World Values Survey and health states were measured by prevalence of chronic diseases and EQ-5D, representing objective and subjective health status, respectively. To estimate the likelihood of reporting happiness, logistic regression was used. Results: Gender differences was insignificant, while individuals with a higher education level and in a higher income group were more likely to report happiness. The difference between age groups was of no statistical significance when subjective health status was controlled. The likelihood of respondents with one or with multiple chronic diseases reporting happiness was significantly lower than those without, but the impact of multiple conditions became insignificant when subjective health states were controlled. The dimensions pain/discomfort and anxiety/depression had substantial negative effects on SWB with anxiety/depression exerting the strongest effect (OR=0.07). Conclusions: It is people who have the final say in whether health services have improved their health. SWB could capture the full impact of health states and therefore could enable an overall assessment of China's health system reform from a novel perspective. Receiving much less attention than physical health, mental health is the principal determinant of SWB. Its development needs greater support from government, while the complete move away from physical health should be avoided.
Promoting health equity through health systems research priority-setting processes: A conceptual exploration for justice in health

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ABSTRACT
Growing calls for donors to align health systems research (HSR) with national research priorities often rest on the implicit assumption that such priorities exist and reflect a just outcome. Yet many low and middle-income countries have not set national HSR priorities and there has been limited consideration of what constitutes a just priority-setting process for HSR to guide countries. This conceptual work argues that HSR priority-setting processes should be designed to promote health equity as a matter of justice and provides an initial account of what the procedural and substantive requirements for such a process might be. The account is derived from a theory of justice that calls for reducing shortfall inequalities in health between and within countries and that considers HSR a required investment for doing so. Necessary for this work, the theory describes the features of a just health system and a model of health governance that can inform an account of HSR priority-setting. Equity-oriented HSR priority-setting should meet the following procedural requirements: 1) rely on interpretive priority-setting methods rather than disease-driven methods, 2) be inclusive, 3) be consensus-promoting, and 4) utilise an equity criterion to rank priorities that is weighted heavily relative to other ranking criteria. Here, inclusiveness is further defined as achieving three elements: breadth, qualitative equality, and depth of non-elite participation. Consensus is encouraged through a deliberative priority-setting process in which all participants have an opportunity to voice their ideas and critically examine the ideas of others. Equity-oriented HSR priority-setting also has substantive requirements: achieving consensus on priorities, where consensus is defined as joint intentions rather than aggregate preferences, and generating priorities that advance equal access to high-quality public health and health care goods and services and equitable financing. The target audience for this work includes: health policymakers, health systems researchers, and civil society organisations.
Caesarean section rate in Mozambique in 1995-2011

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ABSTRACT

Background: Caesarean section (C-section) rate is used as an indicator for availability and utilisation of life-saving obstetric services. In most African countries concern centres on underuse of C-sections and increasing socio-economic inequality in access the service. This study investigated changes in C-section rates in 1995-2011 in Mozambique between urban and rural areas across regions, and examined association between giving birth by C-section and maternal socioeconomic factors. Method: We used the cross-sectional data from the Demographic and Health Surveys conducted in Mozambique in 1997, 2003 and 2011. Women having a live birth within 3 years prior to the survey were included in this study. The association between having a C-section and social and maternal characteristics was studied by logistic regressions. Results: Overall, C-section rate had a modest increase from 2% in 1995-1997 to 4% in 2009-2011. In 2009-2011 in urban areas C-section rates were highest in the southern region (12%), followed by the central (9%) and northern regions (6%). In rural areas, the rate was 4% in the southern region and less than 2% in the other two regions. Highest rate (13%) was found among the women from the richest households. Most C-sections occurred in public hospitals over the study periods. There was no C-section in private and other facilities in 1995-1997, but 9% of births occurred by C-section in these facilities in 2009-2011. After adjusting for maternal education and parity, women who lived in cities and the southern region, and were from the richest households were more likely to have a C-section than women who lived in rural areas and the northern region, and were from the poor households. Conclusion: In Mozambique, underuse of C-section still seemed to be a problem among poor and rural areas, but overuse in the most advantage groups seemed to be emerging.
Inequity of equalization: analysis on the benefit equality of the urban residents' basic medical insurance in China

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ABSTRACT

Equity is one of the basic principles of the social health insurance approach. This paper evaluates the benefit equality of the Urban Residents' Basic Medical Insurance (URBMI) in China which covers 300 million urban populations. From the theory model, we find that, for equalized designed social health insurance which is equally financed and reimbursed among insured, the lower income group will benefit less than higher income. Using the 2007-2011 State Council URBMI Household Survey data, we apply the conventional estimation methodology (two-part model and Heckman selection model), and find the similar results with the theoretical prediction of the unequal benefits among income groups. This translates to the huge investments by the China government which subsidize the premiums of the basic health insurance programs to promote the universal coverage flow to the rich more. Our study provides new evidence on reforming China's health insurance system policies, and it bears meaningful policy implication for other developing countries facing similar health insurance challenges. Key Words: Equity, Benefit, Health Insurance, Health Reform, China JEL Classification: I10, H51, D10
My family is covered not me... lessons learnt from the national health insurance scheme (RSBY) in Karnataka.

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ABSTRACT

Introduction: Recent social protection schemes in India like RBSY, Food Security Act, etc targets the household and not the individual assuming a unitary model of resource allocation. However studies show that within Indian households, different members often have different bargaining powers on resource allocation i.e. collective model. For instance, women have limited mobility, restricted access to financial resources and poorly participate in decision-making. Given this context, we explore what happens inside enrolled households in RSBY that covers upto five household members. Method: Our larger study assessed social exclusion in relation to accessing RSBY in Karnataka, India. First, we reviewed literature on resource-allocation within households. Survey findings of 1988 RSBY enrolled households were analysed to gain an overview. we conducted fourteen in-depth interviews with head-of-households and excluded members in large households. The interviews were transcribed and coded using the basic principles of grounded-theory. Result: Among enrolled small households (?5 members, n=1284), 52% were partly covered; reasons being misinformation about scheme/process, absent-at-enrolment, extremes-of-age, etc. Among enrolled large households (>5members, n=706), 63% enrolled <5 members for similar reasons. In nearly all remaining households, the head-of-household and spouse were always enrolled due to RSBY's design. However, children were excluded in two-third households, and exclusively in one-third. Among adults, women were excluded in three-fourth, while exclusively in nearly half-the-households. Interviews revealed daughter-in-laws and other women are not consulted in such decision-making, and have no voice to request inclusion in them, often believing that since men bring in larger incomes, they rightfully have a say in these matters. Conclusion: Just like in society, exclusionary processes determined by socio-cultural factors within the household influence individual's access to health schemes particularly women and young children. We call this 'intrahousehold-exclusion' and this will remain an important limitation to policies like RSBY that stop at household's doorstep. Hence we conclude that household-centredness is not the same as people-centredness.
Government and civil society response to viral hepatitis

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ABSTRACT

Background Viral hepatitis is a major global public health challenge affecting hundreds of millions of people around the world. It is the most common cause of liver disease and responsible for an estimated two million deaths annually. On World Hepatitis Day 2013, the World Health Organization (WHO) published its first global policy report based on government responses to viral hepatitis, focusing on the four axes addressed in their recently crafted strategy. While official government reports on their response to major infectious diseases such as viral hepatitis are essential to policy-making, experience from the HIV epidemic has exemplified the importance of involving the community in order to respond effectively to major infectious diseases.

Method The World Hepatitis Alliance, a patient-led organisation, commissioned a response to the WHO report and in February 2014 a survey was sent out to 611 civil society organisations in 190 countries. The organisations were asked to discuss the response to viral hepatitis in their country and, if applicable, respond to their government's response to viral hepatitis in terms of indicating whether they judged the information to be accurate or inaccurate. This presentation will present the findings from this first global hepatitis survey of non-state actors.

Significance An effective health systems response requires input from both governments and the affected populations. Understanding civil society views, at the local and national levels, is a central component in securing that the patient, the individual, benefits from international approaches and strategies. Comparing the results from the survey completed by WHO members states in 2013 and those from civil society organisations in 2014 will contribute to a more holistic response to what is still called 'a silent epidemic'.
Neglect of health and health systems in the environmental impact assessment policy and process in India

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ABSTRACT

Background: Environmental Impact Assessments (EIA) of proposed developmental and industrial projects are mandatory in India. The EIA Notification of 2006 provides rules for the governance and implementation of EIAs. Health Impact Assessment (HIA) is considered implicit under the EIA notification. Several projects are being cleared allegedly without adequate considerations towards health, health systems and the environment. Industrial projects are usually located in areas inhabited by marginalised and vulnerable communities. There is a need to evaluate the EIA Notification and processes to understand their adequacy towards accounting health impact.

Method: The framework developed by Parry and Kemm (2006) was supplemented with innovations from Winkler (2010, 2011) and Birley (2011) for the evaluation. Three documents were evaluated: a) The EIA Notification 2006 (India); b) an EIA report of a proposed coal mine, and c) an EIA report of a proposed thermal power project. The gaps were identified and findings compared with other evidence.

Results: The EIA Notification neither included a definition of health nor provided a separate section on health or health systems impact assessment. Its application is restricted to a list of industries included in the notification. Large gaps exist in the guidelines to identify health impacts of proposed projects. The two case reports also demonstrated a lack of focus on health. The special provisions for communicating plans and impacts with tribal and linguistic communities were inadequate. The impacts on displaced communities and the health system requirements of in-migrating communities have largely been under-reported. Conclusions: The gaps identified show a neglect of health and health systems impacts of proposed projects. The policy focus of the government is towards increase the country’s production and revenue, and costs are being externalised on marginalised communities and the environment in the process. HIAs could serve as an important step towards health equity and sustainable development.
Variations in responsiveness of health care services in Nigeria: Insured and uninsured perspectives

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ABSTRACT

Background Responsiveness towards people-centered care is an important performance outcome of effective health systems, but has received little attention in developing countries, amid reforms. The concept of responsiveness is multi-dimensional and relates to the system’s ability to respond to service users’ legitimate expectations of non-therapeutic aspects. We used this concept to evaluate how the system responds to patient-centered care in Nigeria, and examine variations between insured and uninsured users. Methods Responsiveness was assessed across various domains including prompt attention, dignity, communication, autonomy, choice of provider, and quality of facilities. This retrospective survey took place between October 2010 and March 2011. 1669 users, including 796 insured and 873 uninsured in Kaduna State-Nigeria, were interviewed. Chi-square and Wilcoxon rank-sum tests were used to identify the variations in the systems' responsiveness of patient-centered care. Results Respondents (insured and uninsured) had significant variations in reported levels of importance of all responsiveness domains. However, according to their experiences relating to patient-centered care, there were only significant variations in reported levels of prompt attention (p=<0.005), communication (p=<0.005), and quality of facilities (p=<0.001). Users showed no significant difference in type of facility visited, gender, and referral of care. There were differences in other users characteristics including educational status, income level, type of marital status, visits to health providers, and refusal of health care. Conclusions Assessing variations in responsiveness is valuable in investigating systems' patient-centered care. Health care providers in Nigeria should pay attention to the domains of prompt attention, communication, and quality of facilities in reducing disparity based on users status (insured and uninsured), and as priority areas for action to improve on patient-centered care. Regulatory agencies should ensure that the system responds to people’s expectations regardless of their status, and to lessen the gap that might lead to inequality in the system.
From the local to the global and back-again: What can the right to health offer to the post-2015 health development agenda and related domestic health policies?

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ABSTRACT

Purpose: The right to health is increasingly gaining traction in international policy arenas as providing legal and ethical principles to formulate health goals to replace the Millennium Development Goals which expire in 2015. While the use of right to health language increasingly permeates discussions on post-2015 health development goals, it is less clear how these standards, rights and duties should guide policy action at both the domestic and global level that seeks to advance realization of this right. Focus: This presentation will focus on how social groups and academic researchers can utilize the norms and standards of the right to health in international law to influence the formulation of the post-2015 health development agenda and ensuing domestic policies to implement same. It will explore the current status of the right to health within the post-2015 process; outline what the right to health might offer to advancing equitable, available, affordable and accessible universal health coverage; and conclude with thoughts about what actors at various levels might contribute to the achievement of this goal. Significance: This presentation will offer human rights analysis of a pressing contemporary global health policy initiative. It is relevant to social actors, academics and policy-makers.
Socioeconomic inequalities vis-à-vis informal payments for health care in 18 countries in Sub-Saharan Africa: Does gender matter?

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ABSTRACT

Background: Little empirical evidence exists on the magnitude of health care informal payments in Sub-Saharan Africa. Moreover, no work on social disparities in informal payments has been carried out in this region where health financing mainly relies on households’ out-of-pocket expenditure. We assess socioeconomic inequalities in health care informal payments in Sub-Saharan Africa and attempt to explain the observed disparities between men and women. Methods: We use data from the Afrobarometer round 3 surveys conducted in 18 countries from 2005 to 2006. Incidence of informal payments is defined for individuals who faced demands for 'illegal payments' in public hospitals at least once during the year preceding the interview. Education, socioeconomic status and place of residence are used to capture social dimensions. We compute normalized concentration indexes to appraise inequalities across socioeconomic groups, both for men and women. Preliminary results: The pattern changes with the gender in some countries: in Nigeria, Senegal and Botswana, informal payments mostly affect the worse-off men and the better-off women, while the opposite is observed in Ghana, Zambia and Malawi. Also, in Senegal, Benin, Mozambique, Namibia and Uganda, the less educated women and the most educated men are more likely to incur informal payments. The inverse is observed in Nigeria, Kenya, Lesotho, Zimbabwe, Madagascar, Zambia and Botswana. Women living in rural areas and men living in urban areas are more affected by informal payments in Lesotho, Namibia, Malawi and Madagascar, while the opposite is observed in Zambia and Cape Verde. Conclusions: Results show that socioeconomic disparities in informal payments in several countries in Sub-Saharan Africa vary depending on whether men or women are considered. This is probably due to the cultural context of each country (e.g. status of women in society), as well as to the implemented health policies. We intend to use micro-simulations to decompose the observed inequalities, in order to identify the most important factors.
Developing a framework for monitoring the social determinants of health equity in relation to universal health coverage in Vietnam

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ABSTRACT
Developing a framework for monitoring the social determinants of health equity in relation to Universal Health Coverage in Vietnam

Background: In Vietnam, monitoring social determinants social determinants of health equity in relation to Universal Health Coverage (UHC) has been considered as a tool to facilitate progress towards UHC through providing information on why coverage is lower for disadvantaged groups. This research aims to evaluate develop a monitoring framework with a set of indicators and evaluate their feasibility, reliability and policy relevance. Methods: We conducted a systematic review of literature to identify a specific set of barrier/determinant domains for the framework. We then tested the proposed indicators with respect to their feasibility, reliability and policy relevance in tracking progress in UHC and population health. Both quantitative and qualitative approaches were applied. Results: We identified 26 indicators within 11 domains: 1) Income and poverty; 2) Knowledge and education; 3) Community and household infrastructure; 4) Travel; 5) Social protection and employment 6) Early Child Development; 7) Gender norms, roles and relations; 8) Participation; 9) Registration; 10) Discrimination; and 11) Accountability, transparency and anti-corruption. All the indictors were shown to be program/policy relevant but not were seen as reliable and valid for monitoring equity. Some of the indicators were reported to be neither feasible to collect nor easily integrated in existing health information system. 18 indicators were finally selected as the core set for the framework Discussion/conclusions: Monitoring social determinants can speed-up equity-oriented progress towards UHC through providing information on why coverage is lower for disadvantaged groups. The selected indicators should be integrated into the M&E systems of Vietnam Significance for the selected field-building dimension: These materials will encompass advice on Health in All Policies and interventions for addressing health inequities and human rights at the national level
Using photo-voice as a participatory method to explore community perceptions of health

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ABSTRACT

BACKGROUND This photo-voice study forms part of a participatory action research project exploring civil society and community action for the realisation of the right to health. Community participation is a key aspect of the right to health and is an essential aspect of the primary health care approach. However in order to achieve people centred health systems communities have to be empowered to participate and be consulted regarding community health needs. AIM The aim of the study is to explore how members of a community-based organisation understand and take action on health and human rights issues in their community. METHODS Photo-voice has been used in qualitative research in public health to uncover which health issues are of greatest concern to communities. It is considered an empowering method which surfaces ordinary peoples knowledge and understandings and is a potential tool for the social mobilisation of communities. Participants for the study were selected through convenience sampling and were given disposable cameras to take photos of health and human rights issues in their community. They were interviewed individually about the photos and interviews were audio recorded and transcribed. Data was analysed by the researcher using thematic content analysis. RESULTS Participants took photos largely related to the socio-economic determinants of health. Themes identified from the interviews were environmental pollution, substance use, nutrition, the effects of crime and a need for spaces to relax. CONCLUSION Photo-voice is a mechanism by which community members can identify what health means to them. Furthermore, linking this to a human rights based approach enables them to address inequalities in the health system by identifying violations and designing action to address these violations. Thereby supporting people centred health systems.
Socio-economic inequity in maternal, neonatal and child health care utilization in Bangladesh

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ABSTRACT

Background: Reliance on out-of-pocket payment for healthcare leads to catastrophic health expenditure in many households of Bangladesh. A risk-pooling mechanism has been recommended for mitigating such burden. 56.2% people in Bangladesh are dependent on informal sector care, for whom Community Based Health Insurance (CBHI) has been recommended as one of the potential mechanisms for creating affordable access to healthcare. Objective: The objectives of this study were to estimate the willingness-to-pay (WTP) for CBHI and identify its determinants among urban informal workers. Method: The contingent valuation method was used to estimate the weekly WTP. Five hundred workers of three occupations (Rickshaw-pullers, Shop-keepers and Restaurant workers) in three geographic locations (Dhaka (metropolitan city), Chandpur (district town) and Nobinagar (sub-district town)) were interviewed using a structured questionnaire in 2010-11. One-way ANOVA test for testing difference in average WTP across occupations and locations and multiple-regression analysis for predicting WTP by socioeconomic, demographic characteristics, past illness etc. were conducted. Results: For a CBHI scheme 85.8% of informal workers were willing-to-pay. The average WTP was 19.0 BDT (95% confidence interval (CI) 17.2-20.8). This estimation varies significantly across occupational groups (p=0.000) and locations (p=0.003). WTP was highest among rickshaw-pullers (26.0 BDT; 95% CI: 22.4-29.5) followed by restaurant workers (16.1 BDT; 95% CI: 13.6-18.6) and shop keepers (15.3 BDT; 95% CI: 12.5-18.2). In multiple regression analysis, household size, monthly income, occupation, geographical location and educational level were found as the key determinants of WTP. For a 1% increase in household income WTP increased by 8.6% (p=0.048), and for 1 additional member in household the WTP increased by 5.3% (p=0.03). Conclusion: Informal workers in urban areas are willing to pay substantial amounts for CBHI and, socioeconomic differences can explain the magnitude of the WTP.
Health service preference among disadvantaged group in Indonesia: access, financial burden and perceived quality
‘A multi center study through the Indonesian health policy network’

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ABSTRACT

Background: Indonesian has been implementing UHC since January 2014. The aim of this program is to improve access to health facilities, especially for the poor. However, health seeking behavior of poor people is not only influenced by the availability of health services and coverage of health insurance provided by government but also by factors that are not well recognized by health system. Methods: This study combines quantitative and qualitative designs to explore the utilization of health facilities, especially by the poor. We analyzed the relationship of some key determinants to the utilization of primary health care facilities. This study was conducted in 14 districts in two provinces (East Java and East Nusa Tenggara) from 2012 - 2013. The samples for quantitative study were 5010 poor households. We involved 240 respondents in the qualitative study. FGD and in-depth interview were performed to obtain qualitative data. Results: The government-owned health facilities is still the main choice for the poor. Village health post remains the most utilized by poor household (40,3\%), while primary health center is the second option (38,5\%). Mode of transport, travel time, travel cost, service time, and perceived quality are significantly correlated to the use of health care by the poor (p<0,05). Unfortunately, existing UHC does not cover transportation cost (both in primary care and referral case). Quantitative data also depict that perceived quality is influenced by health worker attitude and hospitality during service. Cultural factors such as a collective understanding and experience of particular treatment, as well as strong role of community leaders, tend to determine community preference. Conclusion: Access, financial-related factors and perceived quality determine utilization of health care by poor people. Although UHC has been implemented, health system should address these determinants to ensure disadvantaged people's needs fully facilitated.
Achieving a people-centered health system through human rights: A case study on rights-based approaches to family planning in India and Kenya

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ABSTRACT

Background: Human rights are enshrined in health through international standards, including General Comment 14, the Right to Health in the International Covenant on Economic, Social and Cultural Rights, in which national governments pledged to provide citizens with the highest attainable standard of health. For people-centered health systems to be strengthened, human rights should be at the core, as it places value on the dignity of individuals themselves. But what do rights in health mean in implementation? In October 2013 and January 2014, the Futures Group held national and local consultations in India and Kenya to understand the feasibility and desirability of implementing a rights-based approach to family planning. Methods: Consultations were held in Delhi and Bihar, India, and Nairobi and Embu County, Kenya. A presentation on a framework for incorporating rights into family planning and case studies were used to prompt discussion. Policymakers, international organization representatives, program implementers, service providers and local organization representatives participated. Project site visits were conducted in each country to examine if rights are manifested within service facilities and communities. Results: Stakeholders in both countries were familiar with human rights or a rights-based approach to health, though understanding of how to implement this approach varied. The distinct perspectives illustrate the importance of an enabling environment for integrating rights into health programming. The site visits provided first-hand observations of how rights are manifested in health facilities, and challenges related to quality of care, gender equality, and contraceptive method mix. Discussion: The approach in India and Kenya prompted questioning and strategizing by the stakeholders for how to make human rights an integrated part of their family planning programs and overall health system. The consultations allowed stakeholders to assess the gaps and challenges within programs and health system as related to human rights.
What supports do health system organizations have in place to facilitate evidence-informed decision-making?

A qualitative study

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ABSTRACT

Background Decisions regarding health systems are sometimes made without the input of timely and reliable evidence, leading to less than optimal health outcomes. Healthcare organizations can implement tools and infrastructures to support the use of research evidence to inform decision-making. The purpose of this study was to profile the supports and instruments (i.e., programs, interventions, instruments or tools) that healthcare organizations currently have in place and which ones were perceived to facilitate evidence-informed decision-making. Methods In-depth semi-structured telephone interviews were conducted with individuals in three different types of positions (i.e., a senior management team member, a library manager, and a ‘knowledge broker’) in three types of healthcare organizations (i.e., regional health authorities, hospitals and primary care practices) in two Canadian provinces (i.e., Ontario and Quebec). The interviews were taped, transcribed, and then analyzed thematically using NVivo 9 data analysis software. Results A total of 57 interviews were conducted in 25 organizations in Ontario and Quebec. The main findings suggest that, for the healthcare organizations that participated in this study, the following supports facilitate evidence-informed decision-making: facilitating roles that actively promote research use within the organization; establishing ties to researchers and opinion leaders outside the organization; a technical infrastructure that provides access to research evidence, such as databases; and provision and participation in training programs to enhance staff’s capacity building. Conclusions This study identified the need for having a receptive climate, which laid the foundation for the implementation of other tangible initiatives and supported the use of research in decision-making. This study adds to the literature on organizational efforts that can increase the use of research evidence in decision-making. Some of the identified supports may increase the use of research evidence by decision-makers, which may then lead to more informed decisions, and hopefully to a strengthened health system and improved health.
Realist evaluation of pilot rehabilitation programs in 7 cities in China

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ABSTRACT

Since the end of 2010 pilot programs in 46 cities of 14 provinces have been initiated by the Ministry of Health in China to establish formal arrangements for facilitating the delivery of continuous medical rehabilitative care for local communities. A series of regulations and policies were issued out to define the roles of health facilities at different levels and encourage coordination and networking between them, and to set up quality indicators and clinical protocols. Without extra budget from the central finance, the local health authorities were expected to liaise with other related resource-holding government agencies to mobilize local resources and develop proper models for effective and efficient medical rehabilitation. An external evaluation has been initiated ever since the design stage of the national pilot program. Mid-term evaluation at end of 2012 showed mixed outcomes in terms of rehabilitative infrastructure development, goal-attainment rates, and performance of pilot facilities have been observed, which was not very helpful for rendering evidence for further decision-making. As a result, a realist evaluation approach has been applied to the final evaluation. Program theories of typical local programs in 7 cities including Beijing, Shanghai and Harbin were studied by relating outcome patterns with specific local contexts and mechanisms, to analyze innovativeness and cost-effectiveness of different local models, and draw up common preconditions and requirements for successful implementation. Findings showed that there emerged a common outcome pattern of shortened inpatient stay, improved continuity and quality of care, better patient outcomes and more cost-effective use of regional rehabilitation resources. A call for better coordinated medical rehabilitation and other social care was voiced by most localities. Key words: rehabilitation; pilot programs; realist evaluation; cost-effectiveness
Validating a scorecard to assess and catalyze progress on PHC reform in Nigeria

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ABSTRACT

Background: The Primary Health Care (PHC) Under One Roof model (PHCUOR) is a health system reform promoted since 2010 by the Nigerian federal government to address the fragmented and ineffective delivery of PHC services at lower levels. The reform centralizes all PHC management, planning and financial functions into State Primary Health Care Agencies or Boards. Twenty-three of 37 states have established PHCUOR structures; however, the functionality of these Agencies varies considerably. To accelerate the pace and effectiveness of the reform, a quantitative measure of progress was needed to drive advocacy. Methods: Based on 9 domains (governance, legislature, minimum service package, repositioning, system development, operational guideline, human resources, funding and office set-up) established by the national PHCUOR guidelines, an initial scorecard was developed, but was found insufficiently discriminatory. We revised the assessment tool from 88 to 47 questions, critically evaluating each domain with a series of 2-10 yes/no questions scaled to 100% per domain. Phone interviews were then conducted with key respondents from all states. Results: The reform has evolved slowly; the national average is 44% on all domains. Legislation was strongest (68%) and repositioning and funding weakest (30 and 31% respectively). Progress varied by zones; the Northwest and Southeast were strongest (53%) and weakest (24%) respectively. Although known to have weaker health systems, the Northwest and Northeast scored high marks perhaps from recent health systems strengthening efforts. Discussion/conclusion: The scorecard has created visibility around PHC reforms, generated strong reactions and catalyzed discussions among stakeholders about bottlenecks and solutions. We plan to publish the scorecard in the national media and present the results to state governors. By synthesizing complex system processes into quantitative measures of progress and potentially, peer pressure, we have developed a tool for advocacy to political leaders to influence policy implementation and adoption of the PHC reforms.
Using qualitative methods to improve health system responsiveness in the Western Highlands of Guatemala

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ABSTRACT

Background As a result of the 36 year civil war and Peace Accords signed in 1996, efforts were made to formally recognize the rights and protection of indigenous peoples, including access to appropriate healthcare in Guatemala. While access to and coverage of health services has improved, indigenous populations remain socially excluded and demand for biomedical health care remains low. Methods A local NGO contracted by the Ministry of Health is currently conducting an evaluation of their maternal child and nutrition health services. Focus group discussions and interviews are being implemented in a sample of 15 (predominantly indigenous) communities in the Western Highlands, including hard-to-reach villages. The principle aim is to generate data for decision-making and service delivery improvement, through giving voice to the experiences of the population, and by seeking their input on how to improve health service delivery and uptake. Results Preliminary results indicate even when biomedical care is accessible, traditional health care is often preferred as it is more responsive to the demands of the population. Poor interpersonal interactions marked with lack of respect and mistreatment further contributes to inequity and social isolation of indigenous peoples. Results have implications for service delivery institutions and universities. Discussion/Conclusions Qualitative research is a powerful method and an intervention in its own right. It engenders community participation and reflection, but is underutilized and often viewed as an inferior method. Including the use of mixed methods and valuing qualitative data allows for the examination of the complexity of (in this case) multiple health systems, and of how culture, values and power dynamics affect health care utilization. Achieving people-centered care will not be attainable by addressing only 'traditional' health system indicators. Instead a focus on socio-cultural determinants including how to foster respect and improve interpersonal communication among patients and providers is required.
Quality assurance in HSR: Providing reflexive guidance for enhancing the robustness of health system interventions

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ABSTRACT

Background A key challenge in health systems research is to assure the quality of complex health system interventions (HSI). Traditional quality assurance (TQA) approaches such as the hierarchy of evidence and GRADE seem poorly applicable to complex, multi-component HSI, that are configurations that have to be realized in a local situation. The aim of this study was to analyze experiences with applying TQA approaches to HSI and develop a more inclusive and appropriate approach for providing central guidance for the improvement of HSI. Method We conducted an extensive literature review and interviewed 39 selected key-informants from research, policy and practice who were involved in the assessment of diverse health system interventions in the Netherlands and South Africa. Results TQA approaches are expected to contribute to two improvement dynamics: 1) the improvement of available HSI and 2) the improvement of the functioning of HSI in practice. While the describing and rating of HSI promotes learning and enhances the transferability of interventions, TQA approaches seem too limited to effectively steer and stimulate these two improvement dynamics. Expert committees struggle with a lack of norms for relevant effects and questions about how effects are best studied and rated. Moreover, TQA approaches fail to encourage the improvement of aspects 'like applicability and costs' deemed important by policymakers and practitioners. While TQA neglect the local adaptation of interventions, stakeholders worry that the lack of proven effectiveness will legitimize cutbacks rather than advance health system improvements. Conclusion To better contribute to improving HSI, a more inclusive, participatory and reflexive 'guidance' approach seems required; one which stimulates not just the improvement of effectiveness, but the social learning processes and improvement of different aspects that make a HSI robust. The 'robustness' of HSI shows in its ability to 'function' for diverse stakeholders and in changing circumstances.
Not just theory -- aligning principles of 'harnessing complexity' in purposive complex adaptive systems with sustainability design in community health practice

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ABSTRACT

PURPOSE The study of complexity in social systems has benefited substantially from theoretical research, economic models, and computational models of social and organizational behavior. In parallel, health systems professionals have come to identify systems science as an important direction for implementation research on the complexities of real-world health systems development. Our presentation contributes to building bridges between complexity science's theoretical research on one hand, and community health implementation research on the other. FOCUS We use University of Michigan's Robert Axelrod and Michael Cohen's eight principles for influencing purposeful complex adaptive systems ('Harnessing Complexity,' 2001) as an organizing framework, and review documented positive and negative lessons about sustainability from Community Health projects. Drawing from the diversity of experience of the authors, we use positive and negative experiences documented in program evaluations and post-project sustainability evaluations to illustrate the extent to which harnessing complexity- principles can be usefully adapted to the practice of community health. We consider projects and programs implemented over the last 10 years, most at district level, but also at multi-district and national levels, through different types of partnerships, primarily but not exclusively in Bangladesh, Guinea, Rwanda, and Nepal. SIGNIFICANCE The diversity of community health system strengthening practices under review provides positive and negative lessons supporting the validity of the principles being considered (i.e. building networks of reciprocal interaction; generating learning from variation; using social activity to support growth and spread of valued criteria; promoting social capital formation; balancing learning and action; etc.). Complexity science's 'no free lunch' theorem seems to apply to community health, but systems science and community health sustainability research converge toward fundamental principles for people-centered health system development. We offer practical guidelines to be adapted in context in order to guide community health efforts toward 'harnessing complexity' and correspondingly more sustainability.
Why do we stay? health workers motivation experiences from rural communities in three districts Uganda.

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ABSTRACT

Background: A motivated health workforce is the glue of a well functioning health system yet in many LMICs, the workforce still remains the system's most neglected resource. Uganda has persistently had high maternal and neonatal mortality; poor quality of health services has been cited as one of factors contributing to this mortality. Poor health worker motivation directly affects the quality of health services offered and therefore its improvement is critical. More evidence is needed on what influences health workers in rural communities to commit to delivering services despite prevailing system challenges. Methods: Eighteen in-depth interviews were conducted among health workers who were in charge of maternity wards in three districts- Kamuli, Pallisa and Kibuku in Uganda. The interviews generally explored the understanding of motivation and motivating factors for health workers particularly in undeserved rural communities. Results: In all the three districts, health workers understood motivation as something that can inspire someone to continue working or provide expected services to the client. They appreciated the team work that was associated with supervision, information sharing, mentoring, coaching and appreciation. They placed less emphasis on salary amounts and were more concerned with having additional incentives like training and timely salary. Excessive workload coupled with low availability of health workers and lack of annual leave are key de-motivators. Availability of drugs and equipments was particularly important. Accessible facility location together with amenities such as housing, water, electricity were also important and job satisfaction that was linked to job security. Conclusion: Facility based health workers in rural areas value efforts that recognize their human needs in terms of feedback, supervision, mentoring, coaching and their working conditions related to reliability of payment, opportunities for further training and infrastructural supports. These social needs mattered more in terms of motivation than the amount that they are paid.
Provider voices: health system infrastructure and disrespect and abuse during childbirth in Tanzania

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ABSTRACT

Background: Emerging evidence suggests disrespect and abuse (D&A) during facility-based childbirth is a significant barrier to achieving good maternal health outcomes. Most D&A research focuses on user experiences, overlooking systemic barriers faced by healthcare providers. Understanding and addressing these issues is vital to respecting rights of providers as people and enabling them to provide high quality, dignified care. Methods: Mixed-method approach of structured questionnaires administered to healthcare providers working in the maternity ward (n = 50), and 18 in-depth interviews (IDI) with healthcare providers and administrators in a large urban hospital in Tanzania. Results: In structured questionnaires, 22% strongly disagreed that supplies and medications to perform duties were consistently available; only 2% strongly agreed that there is functioning equipment and infrastructure; and 0% strongly agreed there is enough staff to provide quality care. In IDIs, lack of supplies and equipment prevented providers from providing quality care. Some providers reported poor interpersonal care due to tension between users expectations for available commodities and the reality of stock outs. Ten percent reported witnessing D&A in structured questionnaires; all IDIs identified incidence of D&A. Although most reported that D&A were not ‘normal’, many indicated a ‘justification’ of such behaviors if used to ‘save the baby’ or ‘save the mother’, particularly if due to supply and staffing shortages. Many providers mentioned external pressure to avoid maternal and/or infant death during childbirth, suggesting fear of retribution may be a strong motivator behind provider behavior. Conclusion: These data suggest providers may normalize disrespect and abuse due to challenging and overstretched working conditions. Further analysis of health system gaps and their impact on the patient-provider relationship must be addressed in order to fully understand drivers of disrespect and abuse during childbirth, to support and respect providers as people, and to enable them to improve quality of care.
Towards a tool for monitoring volunteer community health worker motivation

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ABSTRACT

Background: Despite a global tendency towards nationwide volunteer community health worker (vCHW) programmes, research on what motivates vCHWs in low-income contexts remains scarce. Moreover, the majority of research in this area tends to be largely qualitative, with no systematic measurements of motivation neither validated nor applied in these contexts. This is the first study that we know of that seeks to validate a psychometric measure of volunteer motivation in a Sub-Saharan African context. Research Objectives: As part of a doctoral dissertation, the purpose of this study was to validate the volunteer functions inventory (VFI) and to contribute to the development of a validated tool for monitoring vCHW motivation in the Sierra Leonean context. Methods: We employed a functional approach to volunteering using self-determination theory as our theoretical framework. The 27 items of the volunteer functions inventory were subjected to principal component analysis using SPSS Version 19.0. Results: We obtained a Kasier-Meyer-Oklin value was 0.838 and our Bartlett's test of Sphericity reached statistical significance (p=0.000), supporting the factorability of the correlation matrix. The results of our Scree Plot revealed a change at around 5 components, with 4 components explaining the majority of the variance. The decision to retain 4 components for further investigation was further supported by the results of our Monte Carlo Parallel Analysis, which showed only four components with Eigenvalues exceeding the criterion values for a randomly generated data matrix of the same size. Discussion/Conclusion: Our results show that the VFI is a valid and reliable instrument to monitor the motivation of vCHWs in this context and offer a suggestion for how CHWs can be better engaged in health systems. The implications of how this scale can be used to help programme managers and community health worker supervisors to support and monitor motivation among vCHWs are discussed.
Regulating dual practice in the Palestinian territories

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ABSTRACT

Dual practice (DP), whereby a health worker combines clinical practice in the public and private sectors, is widespread in low- and middle-income countries. Despite this high prevalence, evidence on the subject is limited: economic theory does not fully explain its occurrence and few studies assess the effects of different policies on DP in a systematic way. This study reviews DP in the Palestinian Territories where recently enacted legislation imposes an outright ban on DP and provides a package of compensation schemes for physicians. The study is based on two surveys: 1. A key informant survey covering MOH staff, hospital and PHC directors, with the following objectives: (i) Understanding the prevalence of dual practice and its impacts on quality of care; (ii) Assessing the existing governance and accountability mechanisms that govern health workers incentives and performance in the public sector; and (iii) Examining the enforceability of the proposed legislation. 2. A providers survey of health professionals, with the following objectives: (i) Understanding the underlying reasons for physicians engagement; and (ii) Examining the impact of enforced regulations on physicians well-being and performance within the proposed compensation package. Our initial results reveal that physicians in the PT overwhelmingly rely on dual practice to compensate for low-wages in the public sector. While a majority of the surveyed believe that dual practice has negative effects on service quality and availability, the existing infrastructure lacks the capacity to absorb full-time physicians. Additionally, the proposed compensation scheme to circumvent the adverse effects of loss of income is not sustainable. The loss of health workers to the private sector is estimated at 10 percent. We recommend a gradual approach to regulating DP which includes tackling the underlying causes including saturated public facilities, lack of output-based payment system, and weak to non-existent monitoring systems.
Human resource capacity, process factors and workflow in the laboratory following the implementation of a new TB diagnostic technology in South Africa

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ABSTRACT

Background Xpert MTB/RIF is a diagnostic that potentially could improve the diagnosis of tuberculosis, particularly in those with HIV. South Africa made the decision to roll-out Xpert in 2012, however concerns were raised about the pressure placed on infrastructure and staff. As part of a wider evaluation of Xpert roll-out (XTEND) we examined the effect of rapid scale-up of this new technology on laboratory organisational systems, human resources, workload and processes. Methods Workflow, capacity and processes were assessed at 22 laboratories in 4 provinces of South Africa. This was done using a mixed methods approach, including discussion with staff and formation of workflow diagrams and timesheets. Results Working hours for staff have shifted due to the manner in which sputum samples are managed. Intervention laboratories had an average increase of 9% night-time work, while control laboratories increased by 17% after roll-out. This has various effects such time given in lieu; concerns around safety; and potentially improving turn-around-times of test results to patients. Initially staff workloads were lower due to calibration of machines, training at clinics and laboratories and referral initiation, but increased as time progressed. As staff become familiar with the test, they establish their own workflow practices. Staff improved their efficiency in processing capacity, increasing (on average) from 67% to 74% in intervention laboratories. One can see a workflow shift, where intervention laboratories use an average of 1.2 to 1.3 staff members for Xpert processing, and 1.4 for microscopy, as opposed to control laboratories who use 0.3 for Xpert and 2.4 for microscopy. Staff generally felt happy with having this new technology especially as less time is spent reviewing slides under a microscope. Conclusion The introduction of Xpert has lead to change in organisation of TB diagnosis, however, the overall workload on staff has not substantially increased and many processes have improved.
Consider the source: Improving the work climate to increase Kenyan health workers' retention and productivity

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ABSTRACT

Background: Shortages of health workers (HWs) in rural and remote areas in Kenya 'partially due to the inability to attract, motivate, and retain HWs' impede quality health service provision and attainment of universal health coverage. Minimal evidence exists on approaches that successfully increase HW retention and productivity. The USAID-funded, IntraHealth-led Capacity Kenya Project (CKP) partnered with the Ministry of Health (MOH) to implement and test the effectiveness of one approach, the Work Climate Improvement Initiative. Methods: A prospective cohort study was conducted at 34 health facilities: 17 intervention and 17 control sites. The project implemented changes to the intervention sites such as introducing new working tools; improving staff welfare; instituting supportive supervision and gender mainstreaming; and strengthening infrastructure, human resources management, and safety practices. A mixed-methods approach was used to assess changes in HW satisfaction, perceptions of working conditions, intention to stay on the job, and productivity. Surveys were conducted with 44 HWs/HW managers and 430 clients, along with 11 key informant interviews and 8 focus group discussions at control and intervention sites. Results: At intervention sites, staff retention increased from 93% to 95%, while retention at control sites dropped from 91% to 89%. More than 50% of intervention staff reported an intention to stay in their post, and job satisfaction rose 30% (52% to 82%) compared with a 12% increase in job satisfaction (52% to 64%) at control sites. With identical remuneration and benefits, HWs at intervention sites perceived their productivity to have improved by 69%, compared with a perceived increase of 47% among controls. Patient flow also improved by 73% (2200 to 3800) in intervention sites versus 52% (1320 to 2000) in control sites. Conclusions: Targeting interventions to improve HW work climate can improve retention and productivity. Supportive supervision and MOH ownership provided the requisite synergy.
Licensed chemical sellers and antimalarial prices in northern Ghana under the affordable medicines facility - Malaria: A mixed methods analysis

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ABSTRACT

Background: The Affordable Medicines Facility - malaria (AMFm) represents an important experiment in using private retail chains to improve access to medicines in low- and middle-income countries. AMFm aimed to make quality-assured artemisinin-based combination therapies (QA.ACTs) accessible at the variety of outlets where citizens treat fevers. In Ghana, where ACTs are legally sold over the counter, Licensed Chemical Sellers (LCS) are a key antimalarial provider. Methods: I use a framework adapted from industrial organization to study a unique, geo-coded data set of 250 LCSs in and around Tamale, Ghana collected explicitly for this study. Through well-integrated quantitative (multiple logistic regression) and qualitative (open thematic analysis) approaches, I analyze: the experiences of LCSs with AMFm; LCS reported compliance with recommended retail prices (RRPs); LCS economic and social explanations for compliance; and associations between LCS objective characteristics - including geo-location - and RRP compliance. Results: We find high stocking of subsidized QA.ACTs and high RRP compliance. 18% of LCSs report selling above the RRP. The majority of non-compliers cite rising prices from their supplier as the major determinant of their own pricing. The majority of non-compliers sold at USD 1.5 rather than the RRP, USD 1.0. Indeed, in the quantitative analysis, RRP compliance is most clearly associated with the distributor prices and with LCS reputation (years in business). Discussion: A driving motivation for experimentally piloting AMFm was to learn whether the QA.ACT subsidy would be passed on to end-line private retailers and, in turn, to consumers. We find that, largely, it is. By considering LCSs both as economic agents and community members, the present analyses accord with, complement and innovate on the large, independent evaluation of AMFm, which focused on prices but neither objective nor perceptual explanations for price-compliance.
Dividing the pie' how does the peripheral health facility in charge respond to various accountability demands?

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ABSTRACT

Background: There is growing realization that people centred health systems cannot ignore the roles of the people who work for the system and the accountability demands they face in the delivery of public services. For the facility in charge, the health facility in which they operate creates the more immediate context for accountability where Ministry of Health (MoH) procedures, rules, routines, and hierarchical relationships shape the pressures and sanctions that hold them to account and influence their behaviours towards colleagues and clients. In addition, individual providers face accountability pressures from professional associations and licensing bodies to meet and maintain standards and values. They also face 'rude' forms of accountability. Taking peripheral health facilities as the immediate context for accountability, this study sort to understand how the in charge of the facility is able to balance answerability to the Principal and community responsiveness.

Methods: Four facilities were purposively selected drawing from the sub county manager's assistance in site selection. This is qualitative action research using a combination of in-depth interviews, observations, document reviews and informal discussions. Results: Two level 2 and two level 3 facilities have been selected, with two of the facilities managed by female in charges and two by male in charges. Diagrams of organograms with reporting lines will indicate the multiplicity of accountability demands for facility in charge. Drawing from Brinkerhoff 2003 decision space framework, the author will define the levels of local discretion available to the facility in charge and how s/he is able to use these in response to accountability demands. Discussions/Conclusions: In addition to growing literature on accountability and health system governance, understanding the various roles of the in charge at the peripheral level of the health systems and the critical decisions that they make is crucial in people centred health systems.
Dual practice by doctors working in South and East Asia: Origins, scope, impact and the options for regulation

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ABSTRACT

Background: Health professionals often undertake private work whilst also employed by government. Such dual practice (DP) is found in both high-income and lower- and middle-income countries (LMIC) around the world, with varying tolerance. We reviewed DP in South and East Asia in the context of the rapidly expanding mixed health systems in this region.

Method: A comprehensive search of the peer-reviewed and grey literature, using the terms 'dual practice', 'dual job holding' and 'multiple job holding' AND 'health sector' through PubMed and Google.

Results: Healthcare uptake in South and East Asia is increasing, particularly through private providers. Appropriately regulated, DP can improve health service access, the range of services offered and doctors’ satisfaction. By contrast, weakly regulated DP can negatively affect public healthcare access, quality, efficiency and equity, as doctors often pursue the balance of public and private work that maximizes their income and other benefits. The environment for regulating DP is evolving rapidly, with improved communications opportunities, increasing literacy and rising civil society, particularly in this region. The options for regulating DP include: (1) those which restrict opportunities for dual practitioners to prioritise income and other benefits over their responsibility to the public; these require a level of regulatory capacity often missing in LMIC governments; and (2) those which tolerate public providers’ private work, but meanwhile encourage adequate services for the general public.

Discussion: Growth of the private sector and weak regulation in South and East Asia increase the risk that dual practitioners will ignore the poor. Responsive and decentred regulation, involving doctors’ professional associations, civil society and other stakeholders is increasingly recommended. Moreover, as governments in LMIC strive for universal health coverage, market and financing opportunities for regulation of DP may arise, particularly involving insurers. This may also improve the current urban-rural imbalance in doctors’ distribution.
What are the challenges of managing Human Resources for Health (HRH): The districts' perspective

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ABSTRACT

Background The decentralisation process in Tanzania devolved the management of Human Resources for Health (HRH) to local government authorities. However, there is a policy-practice gap where local government authorities become implementers of national policies, and the procedures for acquisition, management, supervision and promotion of council health workers are controlled centrally. This paper gathered information related to the experiences and challenges faced by participants (managers and supervisors) in managing human resources in their respective health facilities. Methodology This research focuses on the experiences and challenges of managing health workers at the local level. Data was gathered through focus group discussions with Council Health Management Team (CHMT) and health supervisors from six selected councils in Tanzania. One focus group discussion was held in each of the selected councils comprising of between 9 - 17 participants. Data was thematically analyzed using NVivo software Findings The decentralization policy supported establishment and empowerment of lower level structures to be able to innovate and creatively address their HRH problems. Yet, there is still inadequate awareness and unclear boundaries of management and authority among managers in the councils. Managers and supervisors seem powerless to innovate and thus to some extent have remained passive in implementing decisions and directives from national government. Conclusions District level staff in general seemed to have a good understanding of the HRH management in achieving health system delivery objectives. However, local authorities will require more autonomy, resources and training to understand and play an active part in addressing HRH challenges. In the absence of this, demotivated health workers will continue to be a feature of health systems.
Unwilling or unable? understanding healthcare providers' perspectives on guideline compliance for malaria testing in Ghana

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ABSTRACT

Background: The test-based malaria management guideline in Ghana reflects a 2009 recommendation by the World Health Organization, to confirm suspected cases before providing treatment. The guideline aims to limit inappropriate antimalarial use, which contributes to emerging drug resistance. Rapid diagnostic tests (RDTs) enable confirmatory malaria diagnosis in peripheral settings without microscopy. Yet healthcare providers frequently prescribe antimalarials without a test, or despite negative test results. This study investigated poor providers' compliance with the malaria testing guideline. The findings are useful to streamline antimalarial prescribing practices, to improve malaria management, and to limit drug resistance development in Ghana.

Methods: A focused ethnography conducted between November 2011 and October 2012 involved 50 providers at six different primary healthcare settings in the Atwima-Nwabiagya district. Observations, semi-structured interviews and focus groups involving providers revealed reasons for poor compliance. Consultations with local and national policy representatives identified system-wide factors affecting providers' compliance, including national health insurance.

Results: Poor availability and quality of RDTs, heavy workloads, and insufficient guideline knowledge limited providers' readiness to test before treating suspected malaria. Knowing the risks and consequences of delayed treatment, providers were unwilling to withhold antimalarials from suspected cases. Due to frequent RDT stock outs testing was sporadic, often conducted after treated patients returned with unyielding signs and symptoms. Conclusion: Limited healthcare delivery capacity created tension for providers between recommended and achievable practice standards, which restricted effective guideline implementation. Perceived patient risk and poor RDT quality undermined providers' willingness to test, leading to precautionary treatment practices. These factors interdependently influenced guideline compliance. Training should enhance providers' knowledge of policy, practice, and technology for diagnosing malaria. However, health system capacity-building is critical to bolster providers' confidence in RDT and guideline utility for managing malaria.
Exploring healthcare provider's perceptions of cleanliness in delivery care using photo-elicitation technique.

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ABSTRACT

Background: Sepsis remains one of the important causes of maternal mortality accounting around 15% of maternal deaths. Poor infection control practices not only increases iatrogenic risk to both mothers and babies but also impacts women's satisfaction with delivery care received. With recent increase in rates of institutional deliveries in India, it becomes important to focus on infection control practices in hospitals. Present study explores perception of different cadres of workers and health care providers as people engaged in delivery care for understanding level of cleanliness in delivery care. Methods: Present study was conducted in four selected government health facilities. Photo-elicitation method was utilized as a tool for generating qualitative responses to reflect providers perceptions of cleanliness in delivery care followed by microbiological assessment of perceived visibly clean surfaces in labor room and maternity wards. Results: Health care providers perceived that higher utilization and better patient satisfaction is associated with visibly clean facilities. However, there are issues with processes such as absence of protocols, lack of training of cleaners, human resource shortage, lack of supportive supervision and personal motivation preventing providers to follow appropriate infection control practices. Microbiological examination revealed presence of pathogenic organisms on visibly clean surfaces that were also resistant to commonly used antibiotics indicating visible cleanliness is not a good predictor of microbiological safety. Conclusion: Current study suggests need for training and streamlining processes for infection prevention including use of protocols and evidence based practices. Use of photo-elicitation with microbiology can provide a comprehensive picture on infection control in delivery care as visible clean might not always be microbiological safe.
Measuring impact of HRM interventions: Some methodological challenges

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ABSTRACT

Background Increasing recognition of the critical role of good human resources management (HRM) in the retention and motivation of health workers, has generated a plethora of well-intentioned HRM interventions in many health systems. But in the rush to attract and retain health workers is there a danger of flooding systems with interventions in a manner that makes it difficult to determine what works and why? Social and managerial interventions cannot be easily subjected to randomised controlled trials, but this does not mean that they should not be subjected to rigorous evaluation. This paper discusses the challenges of designing and executing a controlled trial design of a HRM intervention aimed at improving supervision practices in Tanzania and Mozambique. Methods A retrospective analysis of a two-country of a controlled trial intervention to improve supervision practice provides the data for this paper. Each stage of the process is examined from study design, to site selection, to implementation and evaluation and is used to illustrate the potential methodological pitfalls in conducting research of this nature. Results The analysis generates learning on designing studies to prevent cross-site contamination, selection of appropriate and measurable short and long-term indicators, the use of proxy indicators, and triangulation using multi-level data. Conclusion This paper exposes the challenges and proposes some design features that need to be considered in implementing HRM interventions. It has important implications for identifying the most cost-effective interventions for improving health workers job satisfaction, motivation and performance. As such it has relevance for policy makers and researchers engaged in addressing the human resources problems in many low-income countries.
To lead or not to lead. Down with training, up with coaching!!

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ABSTRACT

BACKGROUND: Primary health care managers in rural areas in South Africa are challenged in optimising their leadership role to deliver quality services to patients. A need was identified in a rural underserved district, comprised of two sub-districts, to strengthen leadership and management competencies of health managers in order to improve the quality of care for patients. METHOD: The project applied a participatory action research approach, commencing with a baseline needs assessment using mixed methods. A convenience sample of health managers was surveyed using a standardised questionnaire to assess their management competencies, capacity development needs, and preferred approaches for capacity development. In-depth interviews were conducted with a purposive sample of managers. Questionnaire data was analysed using descriptive statistics. The qualitative data from interviews was analysed through coding and thematic analysis. Results were discussed at district management meetings to clarify the needs and develop a model for leadership and management competency development. RESULTS AND DISCUSSION: A total of 31 (68%) managers completed questionnaires, and 7 were interviewed. Results highlighted the need for workplace based support and training with a focus on people management, leadership and implementation of learned knowledge. A coaching and action learning model was developed. A team of 6 coaches was trained, and provided monthly coaching sessions to 14 facility managers in the two sub-districts. All participating health managers and coaches also met monthly for an action learning circle, to share lessons learnt and provide a forum for joint problem solving. Results of a process and outcome evaluation of the model will be reported at the conference. CONCLUSION: Health managers in a rural district responded positive to a coaching and action learning approach to capacity development. Following the initial positive feedback from participants and results in facilities the District is keen to expand the approach to include all managers.
Study of attrition, availability, and retention of midwife service scheme officers in Nigeria between 2009 and 2012

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ABSTRACT

Background: Nigeria has one of Africa's largest health workforces (approximately 40,000 doctors and 125,000 nurses), yet only 26% of rural women deliver with skilled birth attendants because of the shortage of rural midwives. The Midwives Service Scheme (MSS), established in 2009 to reduce Nigeria's high maternal mortality rate, supplies midwives to rural/remote areas where they are most needed. The IntraHealth International-led, USAID-funded CapacityPlus project collaborated with the National Primary Health Care Development Agency to study factors underpinning attrition, availability, and retention of MSS personnel between 2009 and 2012. A secondary aim was to propose measures for motivating and retaining rural-based midwives.

Methods: The mixed-methods study was conducted in six states in six geopolitical zones. Study participants included 555 midwives (semi-structured interviews about attitudes toward the MSS), 117 stakeholders (in-depth interviews exploring MSS-related perceptions and ideas for improvement), and 395 midwifery clients in 39 focus group discussions exploring views on midwife availability and performance. We also carried out a record review to determine attrition rates of MSS midwives.

Results: Record reviews revealed a mean attrition rate of 16% (2009-2012). The midwife interviews identified irregular payment of salaries, temporary job status, lack of accommodations, and posting far from family as factors contributing to attrition. However, most midwife respondents (82%) also expressed willingness to remain, citing motivating factors such as gaining more experience and providing services to underserved women. Beneficiaries of midwifery services and community leaders reported that the MSS had improved quality of care.

Conclusion: Stakeholders perceive the MSS as having improved quality of care in hard-to-reach areas in Nigeria. The study's principal recommendation—from midwives, clients, and community stakeholders—is that paying more attention to midwives' personal welfare and the factors responsible for attrition urgently needs to be addressed to improve midwife retention and enhance the service scheme's overall effectiveness.
Better HIV care - why does health worker engagement matter?  
A cross-sectional mixed methods study of health worker performance and engagement in Tanzania

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ABSTRACT

Background: Research shows that employees who are more engaged perform better and are more productive in health and other sectors. Almost all evidence comes from middle- or high-income countries and may not be generalizable to low-resource contexts. This study supported by PEPFAR under the USAID HCI and ASSIST Projects, examined the engagement of health workers providing HIV services and explored the relationship between engagement and performance. Methods: This mixed methods cross-sectional study was undertaken in 6 regions and 27 districts. 183 randomly selected health facilities submitted key performance indicators over 6 months (quality of HIV care, resource management), with 1330 completed questionnaires and 50 semi-structured interviews. Data were analyzed using Principal Components Analysis and Cluster Analysis. Qualitative data were audio-recorded, transcribed and analyzed thematically to identify salient issues, patterns and contradictions to constructs identified in quantitative component. Results: Four characteristics of engaged health workers were identified (explaining 50% variance): being a change agent (α 0.75), job satisfaction (α 0.72), accountable (α 0.69), and equitable and client-centered care (α 0.58). The perceived support health workers felt they received from their immediate supervisor and perceived adequacy of competencies to perform were found to influence engagement. The perceived adequacy of inputs (resources) was not found to influence engagement. Cluster analysis found that health facilities that had health workers with below average levels of engagement had three times the proportion of clients that were lost to follow-up (35%) and higher % of children born to HIV-infected mothers started on co-trimoxazole (76% vs 44%). No relationship was found between health worker engagement and other performance indicators. Discussion/conclusion: Employee engagement was associated with performance in complex tasks requiring problem solving, team work and coordination â€“ it thus matters in the context of improving HIV care. There is a need to engage health workers for people-centered care.
Efforts to improve human resource management in Tanzania and Mozambique - developing competency-based training in internal supportive supervision.

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ABSTRACT

Background: Management support and supervision are key elements in retaining and motivating health workers. External supervision from provincial and/or district levels are insufficient to meet health services and workers’ needs. Alternatives are required and internal supportive supervision (ISS) at the facility level seems one possibility. However, supervisors and health workers recognise that at facility level competencies and skills are lacking. Thus, a competency-based training to improve ISS was developed and findings obtained post its implementation are presented.

Methods: Thematic analysis of workshops and focus group discussions with district and facility staff generated material to inform the training programme's focus and content. A total of 82 supervisors in Tanzania and 36 in Mozambique attended the training. A self-evaluation questionnaire measured pre- and post-training levels of confidence to perform core internal supportive supervisory functions. Participants were assessed for the training's utility and applicability.

Results: Pre-training levels of confidence varied across most items. In Mozambique, statistically significant increases in confidence scores were detected for 15 of the 24 supervisory activities assessed. In Tanzania, all supervisors were confident of performing all 24 activities by the end of the training, except for 1 supervisor whose confidence still needed to be improved on 1 item. Participants 'strongly agreed' that all aspects of the training improved their understanding and were relevant to their supervisory roles (Tanzania 95%, Mozambique 89%).

Conclusion: This study demonstrates that tailored training interventions have the potential to provide facility managers and supervisors with the requisite skills, knowledge and confidence to support health workers to effectively fulfil their roles and duties.
A tool to audit gender equality perspectives of human resource policy documents for public sector nurse-midwives in Bangladesh

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ABSTRACT

Background: In Bangladesh public service rules apply equally for male and female workers, but do not necessarily adhere to gender specific requirements to ensure equitable working conditions for the women particularly nurse-midwives (NMs). This is affecting the quality of nursing education and services and thus having an adverse impact on the total health system performance in the country. The Human Resource Management Unit (HRMU), of the Ministry of Health and Family Welfare (MOHFW) has developed the Gender Equality Audit Tool (GEAT) in 2013 to assess current and develop new gender sensitive HR policy documents related to NMs in Bangladesh. Methods: The GEAT analyzes the qualitative aspects and uses an indicative quantitative measurement framework. It assesses presence and absence of key gender provisions related to equity, equality empowerment, working conditions as applicable to a particular HR document and estimates the gender sensitivity in three scoring levels: ‘low’ (1 - 40%); ‘moderate’ (41 - 70%) and ‘high’ (71 - 100%). Results: 11 HR documents for NMs were gender audited by GEAT. Out of 11, gender sensitivity was found to be high in 1 (9.1%), moderate in 9 (81.8%) and low in 1 (9.1%). The process also prioritized revision of 3 documents and identified 4 issues that required policy attention e.g. safety and health, career path, training and education and workplace harassment. Discussion/Conclusion: Though application of a tool to review gender responsiveness of development programs is in practice, a tool exclusively used for document review is relatively absent in the literature. Only exception is the toolkit developed by Peking University (2008) from which the GEAT framework and gender scoring was adapted. The GEAT approach has been effective in identifying crucial areas that require addressing to protect the rights and needs of NMs to build a more equitable working environment for this important health workforce.
Representation of underserved populations in medical education institutions with a social accountability mandate - results from a cross-sectional survey in five THEnet Schools.

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ABSTRACT

Background The Training for Health Equity Network (THEnet) aims to reduce health inequities by supporting health professional education institutions and their graduates to be more responsive to the needs of underserved communities. This network of health professional schools with social accountability mandates and track records of producing students who are likely to work and stay in such communities, conducts cross-institutional research and capacity development to identify effective strategies and policies that help schools strengthen health systems. A key aspect is the recruitment of students from underserved areas, which is hypothesized to increase the likelihood that they will actually work in these areas after graduation. Objective This study describes the diversity of student profile and intention to practice with underserved populations (defined on basis of socioeconomic status, geography and ethnicity/caste/religion). Method This prospective cohort study involved five THEnet medical schools from five countries who administered a standardised questionnaire to first year students. Results were compared with medical schools using standard selection procedures. Results Student demographics differed from those at other schools, with significantly more low income and rural students. 407/810 (50.2%) of all students indicated an intention to practice in a non-urban area after graduation, with likelihood increasing with increasing rurality of primary schooling (p=0.000). Increasing rurality also correlated with a decreasing intent to work abroad (p=0.003). Discussion/conclusions This study demonstrates a link between the selection procedures related to the social accountability mandate of schools, and the diversity of students, and intention to serve. Students will be followed up longitudinally to assess how these intentions translate into practice. Increasing the presence in the medical student body of otherwise underrepresented populations is one of the mechanisms that schools can employ to address priority health needs and current workforce maldistribution.
Unpacking individual, institutional and organisational behaviour in health managers: Results of a realist evaluation of capacity-building in south India

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ABSTRACT

Introduction Health system capacity building interventions are often implemented across local health systems, in order to improve performance of healthcare organisations. However, such interventions work in some settings and not in others. Local health systems, such as districts, could be visualised as complex adaptive systems that respond variously to inputs of capacity building interventions, depending on their local conditions. Realist evaluation can help to make sense of the complex nature of change, advancing complex systems thinking in healthcare evaluation.

Methods We compare the performance of talukas (district sub-units) and explore the contribution of the individual, institutional and contextual factors, using qualitative data (interviews and observation) and quantitative measures of commitment, self-efficacy and supervision style.

Results The talukas of Tumkur responded differently to the intervention in function of individual, institutional and environmental factors. In a taluka with committed staff and a positive intention to make changes, the intervention worked through aligning with existing opportunities from the decentralisation process to improve performance. However, commitment towards the organisation in isolation was neither essential nor sufficient. Committed staff in two other talukas were unable to actualise their intentions to improve organisational performance, whereas in yet another taluka, the leadership was able to compensate for the lack of commitment.

Conclusion Capacity building of local health systems works through aligning or countering existing relationships between internal (individual and organisational) and external (policy and socio-political environment) attributes of the organisation. The design and implementation of such interventions needs to fit the internal configuration of each setting and identify the opportunities for triggering alignments. By a process of formulating and testing hypotheses, making critical comparisons, discovering empirical patterns and monitoring their scope and extent, a realist evaluation contributes to such context-sensitive analysis and enables a comprehensive assessment of system-wide change in local health systems.
Making decentralisation happen: Developing agency in local health leaders

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ABSTRACT

Background Tanzania’s decentralized system of governance has received much attention since 2000 when the government started to implement local government reform as part of the overall public sector reforms. The reform in Tanzania was guided by the principle of Decentralization by Devolution (DbyD) with a focus on empowering local people through local structures to take their destiny in their own hands. This paper describes how Action Learning Sets (ALS) provide a useful tool in achieving a decentralized system of governance by empowering health leaders and supervisors to take action on local problems. The paper builds on Mollel’s (2010) previous work on decentralisation, incorporating new data gathered between 2011 & 2014.

Methods Primary data is from two sources: 1) a series of workshops conducted in six project districts. The 86 participants consisted of health managers from council and 5 selected facilities [health centre and dispensary]; 2) four rounds of ALS meetings conducted in 3 districts over a period of 12 months with approximately 30 health supervisors participating in each round. Results The ALS methodology allowed members discuss openly and with confidence problems related to their experiences of leadership and supervision. The ALS structure enabled them to make more informed decisions, implement these decisions and observe and report on the consequences, which over time helped them to take more effective courses of action. A sense of agency, innovation and creativity in tackling human resources problems was observed.

Discussion/Conclusion ALS proved a useful tool to empower local leaders and supervisors through its collective and interactive approach. It has considerable scope for improving many aspects of human resource management with limited resources. It provides a promising approach to decentralized decision-making in action and used more widely could be a significant tool in achieving decentralized government in Tanzania.
Magnitude, trends and implications of out-migration among health professionals in Sudan

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ABSTRACT

Background Migration shaped today’s political, social and economic world and become a major influence on the community. Migration of health professionals from developing to rich countries holds impacts on their countries according to their profession, country of origin and goal. The objective of the study is to measure the magnitude, trends and implications of out migration in health professionals [Medical doctors, pharmacists, dentists and nurses].

Methods A Cross-sectional study of both quantitative and qualitative design.

Results The past five years have witnessed a huge out flux among Sudanese health professionals. It is estimated that 41% of Sudanese doctors are working abroad. Health professions of all categories are leaving the country in high rates and in their most productive years, i.e. between the second and early forth decade of life. The main cadres leaving are medical doctors, however what is new is the upcoming pattern of nurse migration. The trend implies the intention to migrate among the health professions is intensifying with no hope to decrease given the numbers of health professions issuing an experience certificate in the past decade rising to boom in the last five years especially 2012. The recent advent of recruitment agencies has accelerated the rate of migration among Sudanese doctors. Sudanese health professionals are mainly attracted by markets in the Gulf.

Conclusion The out migration phenomenon has positive as well as negative implications on the health sector. The positive implications of return migration include the remittances and technology transfer and on the health cadre professional development resulting in a better financial status and overall job satisfaction and more productivity. The negative implications on the health sector are reflected in a disrupted health system due to the substantial loss in the quantity and quality of health professionals as well as loss of higher policy and leadership at key positions.
Motivation and job satisfaction of community health workers in Morogoro Region, Tanzania

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ABSTRACT

Background: In 2012, Tanzania approved national guidelines for an integrated maternal, newborn, and child health community health worker (CHW)- the frontline for Tanzania's community health system. To support retention and performance, as well as to understand CHW needs as community based providers, this study developed contextually adapted scales to measure job satisfaction and motivation. Methods: A census of all CHWs that received training by July 2013 was undertaken in five districts of Morogoro region. CHW satisfaction was assessed through 27 items covering training and service provision; equipment and supplies; supervision; job relations and remuneration. Motivation was assessed through 29 indicators including (a) reasons why you are a CHW; (b) value in the eyes of society and health workers; and (c) workload. Content validity was measured through a parallel qualitative study conducted in the same setting. Reliability tests and factor analysis were used to simplify the scales and compute outcome indices. Results: A total of 227 of 236 CHWs were interviewed in their communities between September and October of 2013. Factor analysis of the job satisfaction scale identified six underlying factors. Ranging from those most problematic (transport and incentives) to those mostly satisfied (supervision, training and registers) to most satisfied (community respect). While factor analysis did not yield a similar result for the motivation scale, parallel qualitative analysis helped to identify commonalities. Differences by sex were not statistically significant, but older and more educated CHWs were more satisfied with incentives, supervision and community respect than other CHWs. Discussion/Conclusion: As efforts gain momentum to rollout a national cadre of CHWs, improved understanding of CHWs as people with heterogeneous needs and ambitions is vital for ensuring sustainability of the program. Study findings highlight areas for programmatic improvement (transport and incentives) and demonstrate the important role of communities supporting CHWs.
Occupational health services utilization among migrant workers in manufacturing enterprises in Guangdong Province, China

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ABSTRACT

Background: During the past decade, the incidence rate of occupational diseases (ODs) injuries has been increasing and caused large disease burden annually. Migrant workers are the most vulnerable population suffering from ODs, who have lower socioeconomic status and have less access to public health occupational health services (OHS). This study aims to report the OHS utilization and its influencing factors among migrants working in manufacturing enterprises of south-China. Methods: This study surveyed 1200 workers (907 migrant workers) exposed to occupational hazard factors in 10 manufacturing enterprises in Guangdong province using structured questionnaire. Univariate analysis and multiple regression analysis were used to explore the associations between individual and organizational characteristics and OHS utilization, with 5% p-value as statistically significant level. Results: This study found that 89.3% and 80.6% workers had occupational health examination before employment and during work respectively, only 50% respondents used personal protection equipment (PPE) effectively, and 63.4% had occupational health training. At the individual level, workers with higher age, higher education, higher income, migrating with family members, having better occupational health knowledge and attitude were tend to higher utilization rate of OHS. Beside those factors, social norms and self-efficacy upon OHS utilization were also correlated with workers’ PPE use. At the organizational level, enterprise scale, and service provisions were found to affect workers’ OHS utilization. Conclusion: It is necessary to enhance government supervision and law enforcement to ensure that all the workers, esp. migrant workers, receive OHS from enterprises. Occupational health education and training are needed to improve workers’ personal protective awareness and to promote interpersonal communication about OHS utilization among migrant workers. This study will contribute to evaluation of strategies for improving health-worker motivation and retention.
Motivation of health workers at primary level facilities in four rural districts of mainland Tanzania

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ABSTRACT

Background Tanzania is one of the 57 crisis countries for Human Resources for Health by World Health Organization. According to the Ministry of Health and Social Welfare, the average percentage of health worker shortage is 65% nationwide and it is greatest at Dispensary level where the shortage is 74%. We visited 103 primary level health facilities in four rural districts of Tanzania in order to understand the motivation of health workers. Methods We administered 45 item self-administered questionnaire to health workers working in Primary Health Care Facilities (Health Centers and Dispensaries) in Nachingwea and Ruangwa Districts in Lindi Region and Mbarali and Rungwe Districts in Mbeya Region in May and September, 2013. In October, 2013, we conducted semi-structured interviews with a sample of health workers in four study districts. Results A total of 266 health workers participated in our study. More than 70% of participants were female. The average age of respondents was 39 years old with the average time in current post of five years. More than a third of our respondents were Medical Attendants (34.2%), followed by Nurse Midwife (32.7%) and Clinical Officers (15.7%). Health workers rated low on the working condition at the facility they work (enough human resources; maintenance of broken equipment). Factor analysis and analysis on qualitative data are being processed and will be ready to share at the conference. Discussion/Conclusions The mean scores of motivation among health workers were 3 out of 4 point Likert scale. However, during the semi-structured interview with health workers, they revealed complaints regarding systems of promotion and compensation for over-time. Health workers proposed innovative mechanism that can easily motivate them without additional resources. Communication through supportive supervision and any other routine mechanism may offer solutions that can be implemented at the district level.
Action learning sets: a novel method to maintain supportive supervision competencies among Tanzanian and Mozambican facility supervisors

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ABSTRACT

Background The skills and knowledge gained in training often fail to be maintained due to lack of support to help trainees translate theory into real-life practice. Action learning sets (ALS) are one methodology used to address this gap, but are infrequently used in sub-Saharan Africa. ALS are proven to effectively form peer group networks that can support skills building and have potential to create sustained collaborative learning and problem solving practices. Methods A controlled trial design was used to evaluate the impact of attending regular ALS across a 12-month period following a one-week intensive training in internal supportive supervision (ISS). The intervention took place with 36 health facility supervisors from three districts in Tanzania and 7 health facility supervisors from one district in Mozambique. Focus group discussions with participants in each district explored changes in attitude to ISS, problem solving and taking action; and the impact on ISS systems and processes at facility level. Additional qualitative data were gathered from ALS meeting reports. Data were thematically analyzed using NVivo software. Results Participants were enthusiastic about their involvement in ALS. They were seen as effective in maintaining competence and confidence in management and supervision of health workers. Reported benefits included enhanced leadership and supervision skills, improved working relationships, teamwork and problem-solving skills. Attendance challenges included competing work commitments and insufficient numbers of staff to provide cover for the participants while they attended Conclusion ALS proved an effective method for supporting learning at the facility level, offering an appropriate, locally available, tailored intervention to increase supervision capacity. The skills and confidence gained were transferrable, with the potential to impact positively on other areas of human resource management. The support of key health sector stakeholders at different levels is necessary to facilitate potential implementation of the ALS process particularly at rural districts that are resources constrained.
Building local human resource capacities for a more responsive public health research system in India

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ABSTRACT

Background: In India, public-health research has been emphasized as a core investment to guide policy and practice in achieving universal healthcare. This study is an analysis of the research capacities in the country, their distribution across different regions, and strategies for individual and institutional capacity-strengthening to create a responsive and dynamic public-health research cadre. Methods: The primary method was a bibliometric analysis of PubMed and IndMed databases for years 2000-2010; this was supplemented by a stakeholder analysis through in-depth interviews. Data were analysed for research output/publications by individual researchers and research institutions, their geographical distribution, stakeholder perceptions about research capacity-strengthening and barriers and facilitators for public-health researchers in India. Results: A total of 7893 articles were analysed for 11 years. While 78.4% papers were produced by Indian institutions, 42.5% of these institutions were concentrated in just three states. Disparities in capacities of the 15 leading research institutions were illustrated by their unequal research output. The seven vulnerable north-eastern states accounted for the least number of research institutions at 1.4%, while the eight poorest states accounted for 12.7% - which together constitute 45.9% of India's population and 56.5% of its poor. These skewed capacities translate to the under-representation of these areas in research studies - only 11% of research is undertaken in these states. Most stakeholders perceived that lack of trained human resources, limited and low quality training opportunities and a complete lack of vibrant, dynamic ecosystem are the main barriers facing researchers in India. Discussion: Research capacities exist, but are unequally distributed in India. If public-health research is to be more representative of people's needs and reflective of contextual realities, the country needs to urgently invest in capacity-strengthening and institution-building efforts. Recognizing and systematically addressing the constraints that researchers face in undertaking their work, would go a long way in fostering an empowered community of human resource for health research.
Health-worker motivation in low and middle income country settings: a systematic review of the literature

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ABSTRACT

Background: Low and middle-income countries (LMICs) face a dual challenge regarding their health workforce: (i) a scarcity of health-workers, especially in rural areas where they are most needed; and (ii) systemic factors affecting the performance of those in post. Understanding and enabling motivation of health-workers plays a role in addressing both challenges & influencing retention and performance of staff & whilst at the same time recognizing them as people embedded within family systems and wider communities, driven by underlying needs, drives and desires, and working under challenging, resource-limited conditions. To date, studies have focused largely on economic, rather than human elements. Methods: Here, we undertake a systematic literature review of financial and non-financial factors influencing the attraction, retention, motivation, and satisfaction of health-workers in LMIC settings. A broad approach was employed initially to capture the full range of evidence available in English since 2002, followed by stricter inclusion/exclusion criteria and a four-level assessment of evidence quality. Results: Of an initial 4341 papers identified, 73 met the inclusion criteria. In these studies, five themes are identified by health providers as influencing their motivation: (i) working condition (54 studies); (ii) financial incentives (46 studies); (iii) social incentives - i.e. recognition and relationships (37 studies); (iv) career development (31 studies); and (v) living conditions (28 studies). We found a scarcity of high quality evidence on the effectiveness of strategies for improving health-worker motivation in LMIC settings. Discussion: This study provides a synthesis of the evidence surrounding health-worker motivation in LMIC settings. We propose that composite interventions are likely to be more successful than those with a single intervention element. Moreover, social incentives such as building stronger relationships may influence motivation as much as more tangible factors. Further research is needed into economic and human factors influencing health-worker motivation in order to generate more effective workforce strategies.
Job satisfaction and motivation among public health workers: longitudinal evidence from Ethiopia

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ABSTRACT

Background: Although human resources for health have received increased attention by health systems decision-makers and researchers in recent years, insufficient attention has been paid to understanding the factors that determine the performance of health workers. This empirical study investigates changes in job satisfaction and motivation over time among public sector health workers in Ethiopia, a low-income country that has embarked on major health reforms and received substantial investments from Global Health Initiatives over the last decade. Methods: The study is based on data from facility and health worker surveys conducted through a convenience sample of 57 primary health care facilities in four regions (Addis Ababa, Oromia, Amhara, and Somali) at three points in time: 2003/04, 2006, and 2009. Both public facilities (43) and private facilities (14) were included in the survey. All health workers present at the time of the survey were interviewed. Using a Likert scale, respondents were asked to respond to statements regarding job satisfaction, pride in work, satisfaction with salary, self-efficacy, satisfaction with facility resources, and self-perceived conscientiousness. Internal consistency of each component of the instrument was assessed using Cronbach's alpha, and indices of worker motivation were calculated for each survey round. Results: Among the sample of public sector health workers, several dimensions of health worker motivation were found to have significantly increased over the study period, including overall job satisfaction, pride, self-efficacy, and self-perceived conscientiousness. However, two dimensions of motivation - satisfaction with salary and satisfaction with facility resources - were found to have significantly decreased. Discussion/Conclusions: Although the study identified several positive changes in health worker motivation, the study also finds that health workers in Ethiopia continue to be dissatisfied with their working conditions and financial remuneration. The implications of the study for Ethiopia's human resources for health policy are discussed.
Putting people before faith: health worker coping strategies to circumvent religious doctrine within a Catholic HIV/AIDS Organization in Tanzania

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ABSTRACT

Background: Faith-based organizations (FBOs) play a large role in health service provision in many low-to-middle income countries (LMICS), employing a large number of health professionals. However, challenges can exist within FBOs in relation to issues surrounding sexual and reproductive health, where policy and approach is often influenced by religious doctrine. Due to theological issues surrounding sexual behaviour, for example, the promotion of condom use for HIV/AIDS prevention is prohibited within many FBOs. Such approaches can create tensions for health workers whose professional beliefs conflict with the position of the organization where they work. Methods: The findings presented are part of a wider study exploring the HIV/AIDS policy processes of faith-based non-governmental organizations (NGOS) in Dar es Salaam, Tanzania. Using a qualitative case-study approach, 24 semi-structured interviews were conducted within the Catholic NGO, along with document review and observation. The data was analysed using thematic framework analysis. Results: Many health workers did not agree with the Catholic Church’s approach to condom use, particularly with regards to high risk groups such as discordant couples, commercial sex workers, and men who have sex with men. These workers felt it important to put the needs of their clients first, and implemented strategies to mediate the tensions between their role as medical professionals and the directives of the Catholic Church. Such strategies included: distinguishing between condom ‘education’ and ‘promotion’, emphasizing individual choice, and framing issues in a way that circumvented religious moral or ethical arguments. Discussion/Conclusions: While many health workers in LMICs work in challenging resource-constrained environments, added challenges can exist for health workers working within FBOs. In contexts where FBOs play a dominant role in health service provision, it is important to understand different health worker coping strategies that exist within such organizations, particularly if appropriate health system strengthening interventions are to be implemented.
New incentive system of benefit convergence between patients and doctors for public hospital reform

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ABSTRACT

Background. A new Health care reform started in Zhejiang Province in China in 2009. The main goal of experiments in several regions this time was to release the financial goal of patients and extend the access to reach health care services. Whether the reform was succeeded or not is important for the stepped reform. Objectives. We analyzed and evaluated the effects of Motivate Mechanism of Public Hospital Reform, and put forward an improved optimization strategy. Methods. We collected the breakdown of payroll scale to compare the fluctuation changes around reform, investigated the incentives of hospitals and evaluated them. Results. The incentive before was mainly dependent on the profit of medicine from the recipe, while the reform emphasized the amount of healthcare service, which has reduced the 'Drug Maintaining Medicine' system and mitigated the problem of 'Poor Access'. It has indeed epitomized the labor value of doctors, but has not meet the need of reform and required improvement according to the psychological and work conditions. Discussion. The recent reform in Zhejiang Province has not involved the fundamental changes of the Motivate Mechanism of Public Hospitals. Problems such as putting undue emphasis on the quantity instead of quality of healthcare service and the increase of misbehavior in medical treatment. It is essential to create a new Motivate Mechanism based on the benefit convergence between doctors and patients, in order to achieve the reform goal of raising healthcare quality and mitigating the problem of 'High Fee'.
Researching people-centred health systems: The reward and challenge of co-production for HPSR

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ABSTRACT
Health Policy and Systems Research is centrally concerned with people, their relationships and the actions and practices they can implement towards better health systems. These concerns suggest that HPS researchers must work in direct engagement with the practitioners and practice central to the inquiry, acknowledging their tacit knowledge and drawing it into generating new insights into health system functioning. Social science perspectives are of particular importance in this field because health policies and health systems are themselves social and political constructs. However, how can social science methodologies such as action research and narrative and appreciative enquiry enable such research, and how can methodologies from different disciplines be woven together to construct and make meaning of evidence for this field? This presentation presents 'methodological reflections' on these points, to prompt discussion on the practice of HPSR. It draws on one long-term collaborative action learning project undertaken in Cape Town, South Africa. The District Innovation and Action Learning for Health System Development project is an action-research partnership between two South African academic institutions and two health authorities focussed on strengthening governance in primary health care. Drawing on this experience, the paper considers three inter-related issues: - The diversity and complexities of practitioner and research actors in co-producing HPSR; - The nature of co-production, and central role of providing space to grapple across different systems of meaning; - The character of evidence and data in co-production. Key messages: - Co-production is an essential dimension of HPSR, as an applied and embedded research field concerned with people and health systems - Co-producing knowledge demands approaches to engagement that allow real understanding of both practitioner and researchers' worlds - Co-production needs time for relationship- and trust-building and flexibility to determine form, shape and deliverables - There is a learning opportunity in making use of and weaving together different forms of data
The scope and causes of the deficit in human resources for primary health care in Uganda.

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ABSTRACT

Introduction Primary health care is widely recognised to be one of the most cost-effective vehicles for delivering life-saving public health interventions. One of the major constraints to delivering these interventions is the shortage of human resources for health. Yet the scope and the causes of the deficit of human resources in primary health care in Uganda have not been well documented. Methods An in-depth analysis of human resources for primary health care in Uganda was done. Information was triangulated from a review of published and grey literature in these countries and participatory research with health workers and other key stakeholders in the countries. Results Quantitative data on staffing in primary health care was available in Uganda; only a minority of the total number of doctors, nurses and midwives are working in primary health care. Shortages of health workers were greater in rural primary health care than in other sectors. Health workers described many difficulties which deter them from working in rural primary health care. Therefore health workers prefer to work in secondary care, private facilities, and in other countries. The participatory research has shown that health workers work in difficult conditions, and that one of the main problems in primary health care facilities is the frequently difficult relationship between health workers and the health unit management committees. Conclusion There are shortages of health workers in every sector, but more so at the lowest levels of health care. Attainment of public health goals requires interventions to address quality as well as quantity of health workers, at every level in the health system.
Non-communicable disease risk factors among health care providers in Timika, Papua Province, Indonesia: A neglected health system bottleneck

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ABSTRACT

Background: There is a tendency to forget that health care providers are people too, and as such are susceptible to the same emerging disease patterns confronting a given region or country. Non-communicable diseases (NCDs) rates are rapidly increasing in Indonesia, accounting for 64% of deaths at the end of 2008. NCDs are expected to impose a massive burden on the national health care system, particularly with the recent roll-out of universal health care coverage. We thus aimed to assess NCD risk factors among health care providers located in eastern Indonesia.

Methods: A convenience sample of 56 nurses, dentists, pharmacists, paramedics, clinicians, and public health professionals were surveyed at two clinical sites within Timika, Papua Province, Indonesia. The voluntary self-administered questionnaire, based on the 'Health Improvement Card' developed by the World Health Professions Alliance, collected data on key demographic, behavioral, and physical characteristics as well as biomarkers from respondents' most recent medical visits.

Results: Of the 42 men and 14 women surveyed, 58% were 20-34 years of age. Mean BMI was 24.8 (SD 3.8) kg/m², 44% reported raised cholesterol (>200 mg/dl), and 10% reported raised blood pressure (SBP>140 mmHg, DBP>90 mmHg). Regarding daily health-related behaviors, 79% reported consuming less than 5 portions of fruit or vegetables, 53% reported exercising less than 30 minutes, and 30% admitted to smoking regularly. None reported heavy alcohol consumption (>5 drinks daily or >5 days weekly) or having raised fasting blood glucose levels (>125 mg/dl) during their last medical visit. Conclusions: This study is the first to assess modifiable NCD risk factors among health care providers in Indonesia, revealing high rates of inadequate fruit and vegetable consumption, sedentary lifestyle, and smoking alongside burdens of overweight and hypercholesterolemia. Findings highlight the critical need for primary prevention of NCDs among health care providers as in the general population.
Fulfilling public mandates in evolving urban health care markets: A qualitative study of municipal health care provision in Pune, India

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ABSTRACT

Rapid urbanization in India is associated with disparities in health care access: rates of childhood immunization and perinatal care among the urban poor are as low as rural averages. Yet municipal health services have seen few upgrades in recent decades, while a largely unregulated private sector continues to expand. Municipal health care providers thus confront a mounting tension between their delimited mandate and unmet needs among the urban poor. This study examines how municipal providers negotiate this tension and its implications for urban health in Pune, a city of three million whose population has more than doubled in 30 years. Methods: Participant observation at municipal outpatient clinics and semi-structured interviews, conducted over eight months, were used to study how municipal providers resolve work dilemmas and relate to the communities they serve. Findings: Municipal providers perceive the poor as largely unresponsive to health counseling, but simultaneously state that clinic-based tasks overtake community outreach. Reflecting upon the high use of private health care among the poor, providers discern changed expectations of care: patients might unreasonably demand prompt clinical attention at municipal facilities, but tolerate similarly long waits when paying for private services. Municipal providers attribute such demands to popular misinformation and overvaluation of private services. Many respond by fulfilling only formal, elementary responsibilities, finding that personal initiative goes unrewarded by both health authorities and the community. Conclusion: In evolving urban markets, private health care can displace municipal services not only in quantity, but also by subverting municipal providers’ incentive to reach the poor. The poor may further disengage from relatively more rational, although limited, municipal services, potentially exacerbating the adverse effects of inequality on urban health. Significance: Findings suggest how marketized health care can shape the social values and norms associated with providing health care, and affect clinical interactions and providers’ motivation in the public sector.
Migration of South African health workers:  
The extent to which financial considerations influence internal flows and external movements

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ABSTRACT

Background: The loss of human resource capacity has had a severe impact on the health system in South Africa. The objective of this study was to determine the role of financial factors in health worker's (HWs) decision to migrate following the implementation of the Occupational Specific Dispensation (OSD) Policy by the South African Department of Health. This policy was designed to attract and retain HWs in the public health sector. Methods: The study uses cross-sectional data from a total of 694 HWs (430 in the public sector, 133 in the NGO sector and 131 in the private sector). An additional 11 HWs were purposively selected for in-depth interviews. Odds ratios with 95% confidence intervals were calculated to determine whether salaries influenced HWs decisions to migrate. Results: The extent to which remuneration is the key motivating factor behind HWs movement within and out of South Africa has been overestimated. HWs decisions to move appear to be motivated by a mixture of factors including high levels of stress as a result of increased workloads and other challenges faced in their current job. The most pressing need is to rectify the mal-distribution of HWs between the public and private sectors and rural and urban areas. Conclusions: The OSD appears to have lowered the risk of HWs migrating due to low salaries. However, the results also indicate that the South African Department of Health needs to improve working conditions for HWs within the public health sector to assist in retention. The results of this study resonate well with the long standing behavioural theories developed by Maslow and Herzberg which suggest that the movement of labour should be understood within the complex processes which shape aspects such as job satisfaction and several other aspects that affect an individual worker.
Informing the scale-up of Kenya's nursing workforce: a mixed-methods study of factors affecting pre-service training capacity and production

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ABSTRACT

Background Given the global nursing shortage and investments to scale-up nurse production, this study evaluated trends in annual student nurse enrollment, pre-service attrition between enrollment and registration, and factors that influence nurse production in Kenya. Methods This study used data from nursing regulatory and deployment databases (i.e. rHRIS, KHWIS) for the quantitative analyses and qualitative data from key informant interviews with nurse training institution educators and administrators. Trends in annual student nurse enrollment from 1999-2010 were analyzed. To assess pre-service attrition between training enrollment and council registration, data for a cohort that enrolled in training from 1999-2004 and completed training by 2010 were analyzed, using multivariate logistic regression to test for factors that significantly affected attrition. To assess the capacity of nurse training institutions for scale-up, qualitative data was obtained through key informant interviews. Results From 1999-2010, 23,350 students enrolled in nurse training in Kenya. While annual new student enrollment doubled between 1999 (1,493) and 2010 (3,030), training institutions reported challenges in their capacity to accommodate students, including congestion at clinical placement sites, limited clinical mentorship by qualified nurses, challenges with faculty recruitment and retention, and inadequate student housing, transportation and classroom space. Pre-service attrition among the cohort that enrolled between 1999-2004 and completed training by 2010 was found to be low (6%). Conclusion To scale-up the nursing workforce in Kenya, concurrent investments in expanding the number of student nurse clinical placement sites, utilizing alternate forms of skills training, hiring more faculty and clinical instructors, and expanding the dormitory and classroom space to accommodate new students are needed to ensure that increases in student enrollment are not at the cost of quality nursing education. Student attrition does not appear to be a concern in Kenya compared to other African countries (10%-40%). Significance Identification of needed improvements in pre-service nurse training.
Does ART task sharing free up time for healthcare workers to provide more non-HIV services? evidence from the 2010 Kenya service provision assessment

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ABSTRACT

Background: Task sharing of duties for HIV services between provider cadres, especially prescription and management of antiretroviral therapy (ART), facilitates scale-up of HIV treatment in countries with healthcare worker (HCW) shortages, while maintaining quality of care. Less is known about whether time efficiency gains from task sharing are directed toward non-HIV services. Methods: The 2010 Kenya Service Provision Assessment (KSPA) was a nationally representative cross-sectional survey of 692 health facilities, and a total of 3032 providers present during the facility visits. For each facility, we quantified task sharing by counting the number of mid-level providers (nurses and clinical officers) who prescribe ART and provide follow-up care. Maternal and child health services outcomes were reported by providers and directly observed by researchers. Using STATA12, we used negative binomial models for three non-HIV service outcomes, regressing utilization counts on task sharing, adjusting for the total number of staff employed in each cadre, number of beds, level of care, and public/private ownership. Results: 261 facilities (38%) offered both baby delivery services and ART. Of those, the total number of deliveries HCWs reported conducting was 15% higher (95% CI=6.0-24.0%) and the number of deliveries during the study visits was 11% higher (95% CI=1.01-1.22) for each additional mid-level provider with ART duties. 267 facilities (39%) offered ART and sick child outpatient services. Of those, the number of sick-child patients expected was 16% higher (95% CI=9.1-23.6%) for each additional mid-level provider with ART duties. The number of antenatal care patients seen was not associated with task sharing (p=0.22). Conclusions: Task sharing may not only increase coverage of HIV services, but may also free time for non-HIV care. People-centered health systems should make the most efficient possible use of limited human resources, especially in countries with high HIV burden. More comprehensive research on provider time use is recommended.
Increasing access to health services in remote and rural areas through improved retention of health workers: Evidence from Sierra Leone

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ABSTRACT

Background In Sierra Leone, failure to attract and retain health workers in rural areas creates a geographic imbalance in the health workforce and challenges the aspirations of achieving health for all. Currently existing 'incentive packages' for the retention of health workers in these areas involve mostly monetary attributes, but very little is known about their effectiveness and sustainability, long-term. Accordingly, the aim of this study was to understand health workers' experiences and career decisions and from these derive recommendations for effective approaches to retain health workers in hard-to-reach areas. Methods A participatory approach was adopted, using life histories. In total, 23 were conducted in four study sites in 2013 with a range of health workers (average length of service of 19 years). The study sites chosen were representative of remoteness as well as urban sites, and included all regions of the country. Results The research highlights the wide range of factors which motivate staff to join the profession, including a sense of service and also attraction to the social and professional status which health work seems to offer. A similar pattern of motivators was found over the workers' careers, while poor team relationships, limited professional autonomy and political interference were significant themes in relation to demotivators. There is willingness - sometimes enthusiasm - to serve in remote areas, as long as staff are not left and forgotten there. For staff in remote areas, it is important to be able to continue to progress their career, to access training and to stay in touch with families (especially for women). Conclusions The lifelines were able to highlight the choices made by health workers and what had influenced them. This tool is powerful in providing insights into what is needed to attract and retain staff within the health system and remote areas, in particular.
Physicians get ill in China: a cross-sectional study on burnout

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ABSTRACT

Background Burnout has been a major concern in the field of occupational health. However, there is a paucity of research exploring physicians’ burnout among different level hospitals in China. Revealing the situation of physicians’ burnout is important to improve the healthcare providers’ health, the quality of healthcare, and resource allocation as well in China. Methods A multi-center cross-sectional survey was conducted from November to December 2013. Hospitals from 10 provinces in China were selected by convenience sampling. Totally 12 tertiary, 9 secondary, and 25 primary hospitals were included in this study. A questionnaire with instruction was distributed to physicians. Burnout was measured using the Chinese version of the Maslach Burnout Inventory-General Survey. Workload was measured by working hours per week and the number of daily service patients. Results Totally 1,537 physicians (882 men, 631 women, and 24 missings) were included in this study. Generally, 76.9% of all physicians got some burnout symptoms or serious burnout. The average working hours per week (Mean ±SD) were 46.6 ±9.1, 52.2 ±11.5, and 56.2±9.9 (<0.001), and the average number of daily service patients (Mean ±SD) were 15.3 ±13.2, 22.8 ±18.3, and 32.1 ±27.7 (<0.001) in primary, secondary, and tertiary hospitals, respectively. Meanwhile, proportions of physicians with some burnout symptoms were 52.6%, 59.0%, and 56.0%; and those of physicians with serious burnout were 10.9%, 17.3%, and 23.7% (<0.001) in primary, secondary, and tertiary hospitals, respectively. Moreover, working hours per week and patient number of daily service were positively correlated with burnout score (Spearman's rho were 0.278 and 0.137, respectively; both p<0.001). Conclusions Burnout is very serious among Chinese physicians, and physicians in tertiary hospitals are especially overworked. Interventions, including special policy, should be considered as soon as possible to improve Chinese doctors' health.
Leadership as identity: Clinical hybrid leaders in Kenyan public hospitals and their role in improving service delivery

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ABSTRACT

Background The growing emphasis on the need to tackle inadequate human resources for health (HRH) as an essential part of health systems strengthening focuses more on macro-level issues such as training, recruitment, skill mix and distribution. Little attempt has been made to understand the capability of health workers, their motivation and other structural & and organizational aspects of systems that influence workforce performance. This study explores what roles hospital clinical unit heads (hybrid clinical leaders) need to play that go beyond their professional competence and help promote effective delivery of high quality services. Context Hospitals are professional bureaucratic organizations characterized by high autonomy and battles of jurisdiction. The socialization process of health professionals and the process of standardization of the profession lead to formation of a professional identity shared by clinicians in hospitals. However, these hybrids perceive need to maintain collegiality towards the profession versus acceptance and enactment of leadership roles. This is true in Kenyan hospitals based on prior experience and ongoing empiric work.

Methods We draw on primary qualitative data, informed by social science, psychology and management studies literature. Through a comparative case study approach 3 county hospitals that vary in the challenges they face their size, the available human resources and the experience of their managers have been selected. We use narratives/ stories and non-participatory observations with the heads of clinical departments and the senior administration of the hospitals and focus group discussions with front line health workers.

Discussion/Conclusion Despite their importance in implementing better practices there is little research on clinical hybrid leaders in low-income settings. Particularly in Kenya, previous work has revealed leadership gaps and poor communication between the senior administration and the lower cadres preventing better practice. Strengthening the roles of hybrid clinical managers in such setting is therefore essential to help improve performance.
New insights into provider productivity and quality: Results from service delivery surveys in 6 SSA countries

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ABSTRACT

Africa’s health spending has been growing rapidly over the past decade. More than 70% of health recurrent spending is on human resources. Yet what these resources buy is the efficiency, productivity and quality of providers is mostly unknown (Soucat 2012). The Service Delivery Indicators surveys (www.SDIndicators.org) collect information on productivity (absence rate, caseload) and intermediate measures of quality (diagnostic accuracy, adherence to clinical guidelines in Tanzania, Senegal, Kenya, Uganda, Nigeria, Togo using multi-stage stratified cluster sample (n= 200-400 facilities per country), yielding nationally representative results, disaggregated by rural/urban, provider-type and facility-level (Martin et al 2014). Absenteeism is a significant problem, ranging between a fifth (Tanzania, Senegal) and a half (Uganda, Togo). More than 80% was sanctioned by management. Absence rates were similar across cadre and more likely among urban providers (p<0.05). Productivity is also low. In Tanzania and Senegal providers spent 29-39 minutes seeing patients per day. Caseload per provider per day ranged from 1.4 (Nigeria) to 10.0 (Uganda). Caseload was highly skewed, equaling 22.3 among busiest 20% of health centers in Kenya. No relationship was detected between caseload and intermediate measures of service quality. Significant gaps in provider ability exists, the lowest in Nigeria and Senegal where providers correctly diagnosed a third of cases (diarrhea, malaria, pneumonia, diabetes, TB). In Kenya, the best performer, only 58% of providers correctly diagnosed 4 out 5 conditions. Adherence to clinical guidelines was a good predictor of diagnostic accuracy, explaining more than 40% of its variation (p<0.005) in Tanzania and Senegal. Data from 6 African countries shows significant gaps in providers' productivity and quality. Increased investment in human resources can only yield returns by increasing the effort provided and addressing the gaps in provider ability. More analysis is needed to understand the respective roles of management practices, changes in incentives and change in behaviors norms in improving the current situation.
No channels, no autonomy, no support system' - nursing governance landscape in India

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ABSTRACT

Background Nurses are the backbone of people-centered health systems. But very little evidence is available in relation to the analysis of policies and institutional performance around nursing governance in India. Delineating the enabling and disabling factors in this context will aid to better understand this sector. Insights into policy challenges and institutional roles and responsibilities in the nursing sector are necessary for good governance in this important sector. Methods The study employed Sheikh and colleagues' backward mapping techniques for policy analysis. The analysis was based on the conceptual framework for health workforce governance of WHO comprising (a) leadership and regulation (b) education and development and (c) deployment and utilization. Existing federal level policies and provisions were reviewed and in-depth interviews of key actors, drawn from health system and nursing associations, were conducted. Results Nursing governance in India is affected by significant issues in the design architecture of federal level policies, as well as in its implementation. Design issues included the possibility of ex-officio non-nursing council members having majority; lack of regularized posts; absence of continuing nurse education programme; faulty and irregular updating of registry; non existence of practice act and lack of policies to safeguard interests of nurses. Key implementation gaps included lack of amendments in the Indian Nursing Council (INC) Act; vacant positions coupled with procedural delay in hiring; deficient budgetary allocation and lack of overall political will. Discussion Lack of leadership opportunities and skill building coupled with medical fraternity dominance result in nurses not being leaders of their professional province. Even though standardized, education curriculum faces implementation and revision challenges. With absent practice act, only education is regulated. Dearth of professional development avenues force nurses to remain with lower salaries; negative motivation and poor working conditions. As people within health systems, nursing providers need strengthening of Governance mechanisms.
Passion, power, and pragmatism. The profound influence of individuals in shaping school health, a priority programme in South Africa

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ABSTRACT

This paper examines the powerful influence of individuals on the fate of school health services, a priority programme in South African health care. It tells the complex story of individual policy makers, managers and implementers and their contribution to the rise, fall and re-prioritisation of school health over the period 2000 to 2013. The paper demonstrates the added complexity of inter-sectoral actors, as the service operates across three departments: health, education and social development. The powerful influence of policy actors in the development and implementation of policy is well-described. While policy power is usually apportioned to high-level actors, the phenomenon of street level bureaucracy examines power at the frontline of implementation. Sandwiched in-between, are numerous managerial layers: some who impact on policy making and others who influence implementation more directly. These reflections on the powerful role of individuals are drawn from a retrospective policy analysis, using qualitative research methods, to explore the roles, perceptions and experiences of approximately 250 actors in school health, across all levels of the health and education system. This paper describes how actions of policy makers led to the intermittent sinking and resurrection of school health. It highlights the missing piece of the story - that of frontline actors in the Departments of Health and Education and their efforts in implementation, against many odds. It addresses the actions of various managers and how these undermine, or support, frontline implementers and policy makers. The paper contributes to the policy analysis field, of interest to policy makers, researchers and practitioners, by highlighting the complex inter-plays between multiple actors, spheres of operation, and sectors and how these shape the health system response for a service that impacts on the lives of 11 million children. It further shows the utility of qualitative research methods in deepening our understanding of these complexities.
Global to local policy transfer in the introduction of new molecular diagnostics for MDR-TB in South Africa

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ABSTRACT

Background New rapid TB diagnostic tests promise to dramatically improve TB programme management through the rapid identification of cases of drug-resistant TB. How such potential is translated into global and national policymaking, and effective programming on the ground, however, is a critical but often poorly understood phenomenon. We analysed the technological development and testing, global and national policy development, and policy implementation in South Africa, for the MDR-TB Plus line probe assay (LPA) and Xpert MTB/RIF diagnostic platforms, to better understand what factors shaped policy transfer in these cases.

Method We conducted a longitudinal qualitative process evaluation with a wide range of stakeholders in the policy transfer process, including policymakers and programme managers at all levels, researchers, private sector technology providers, development organisations, academic researchers, and frontline staff. Analysis of interview and document review data was guided by the Policy Transfer Analysis (PTA) framework. Results Global and national policy development was closely intertwined, with national policy and practice decisions sometimes moving ahead of global policy recommendations. Political factors at the national level exerted a strong influence on the character and pace of policy transfer, as did the place of the laboratory services within the health system. Lines of communication and coordination between different national, provincial and frontline stakeholders were not always clear and resulted in numerous threats to effective implementation.

Discussion and Conclusion Hasty and vertically-driven implementation, lack of operational planning, and lack of monitoring data at the service level limited the potential benefits of rapid diagnostics at the frontline. Many of the weaknesses of the policy transfer process at the national level were underpinned by an assumption that LPA and Xpert were straightforward technical fixes to complicated diagnostic and treatment challenges. A more thorough health systems approach to policy transfer is critical in realising the potential benefits of these new technologies.
Equitable access to health insurance for vulnerable children: The case of the National Health Insurance Scheme (NHIS) in Ghana

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ABSTRACT

Background As part of significant efforts to reduce child mortality and reach universal coverage, Ghana extended free membership of the National Health Insurance Scheme (NHIS) to children (under-18s) in 2008. However, despite the removal of financial barriers, a substantial proportion of children remain uninsured and Ghana, with an under-5 mortality ratio of over 70 per 1000 live births, remains unlikely to achieve Millennium Development Goal 4 by 2015. In this paper we explore whether social exclusion, as measured through a social, political, economic and cultural lens, can explain this low enrolment and if it additionally restricts equitable access to health care. Methods Data were collected from a cross-sectional survey of 4050 representative households conducted in Ghana in 2012. Household indices were created to measure economic, sociocultural and political vulnerability and logistic regressions conducted to study the determinants of enrolment and utilisation of health care. Results Our results indicate that 45.1% of children are not currently enrolled in NHIS. Being from a rural area, having a large number of siblings, living far from a health centre and living in a household at risk of political and economic exclusion significantly reduced the odds of enrolling. NHIS members were more likely to be hospitalised but no significant effects were found for outpatient care. Conclusions Equity in access for vulnerable children has not yet been achieved within the NHIS. Despite children being exempt from paying premiums, the most economically vulnerable are still less likely to enrol. Removing the remaining GHS 1.00 registration fee and de-linking membership from parents' contributions may enhance enrolment among the poorest. In addition, special efforts should be made to enrol those in rural communities. Ensuring equitable access to NHIS will contribute substantially to improving child health and reducing child mortality in Ghana.
Complex systems interventions with faith-based non-profit providers:
Case study of a reproductive health policy intervention with catholic providers in Ghana, Cameroon and Malawi

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ABSTRACT

Faith-based health providers (FBHPs) are a substantial presence in many of Africa's most fragile health systems. They are quintessentially people-centered, usually being non-profit and community-owned, with multi-layered governance structures. However, there is only minimal evidence on how FBHPs fit into their health systems and policy environment. One key policy issue is sexual and reproductive health (SRH) services provided by FBHPs, and Catholic providers in particular. While there is significant advocacy, there is little empirical evidence on what SRH services are provided in Catholic facilities or the governance issues around these. This paper reports on an evaluative three-country case study conducted from January 2013 to February 2014 in Cameroon, Ghana and Malawi. In each country, at least 40 in-depth interviews were conducted with health workers, management and systems stakeholders. Thematic analysis was conducted across the cases drawing on data from interviews, observations, facilities' reporting data, and organizational reports. This paper reports on one element of the case study: to assess the systems effects of a policy intervention initiated by the Catholic funding agency, CORDAID. This intervention sought to improve access by implementing a policy of 'informed decision making' which encourages full information and referral to SRH clients. Three distinct implementation reactions were found, ranging from a back-lash reaction from the Catholic systems leadership, to a nonchalant acceptance of the policy which was seen to fit naturally with existing beliefs and practices. This research demonstrates the complex policy and systems environment in which faith-based providers operate, and the unique governance challenges they face. Managers and health workers are buffered by often conflicting policies from their denominations and governing communities, their national networks, governments, a variety of external funders, as well as 'theology' as a policy and systems influence. Their interpretation of this complex environment impacts directly on systems performance.
Supportive supervision and mentoring: Key to health systems strengthening

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\(^1\) Futures Group

**ABSTRACT**

Purpose/Objective: Health systems strengthening require adequate capacities to manage, monitor, and support facilities and workforce. The USAID-funded Health Policy Project implemented a program (Nov. 2012-July 2013) in Jharkhand State, India, to strengthen capacities at state, district, and sub-district levels to effectively implement and monitor health service delivery with specific focus on FP. Methods: Manager's Tool, a checklist and data collection tool, designed on the basis of WHO's six health systems building blocks, was used to record observations during facility visits to identify gaps, develop action plans, document best practices, provide on-the-job support, and follow up on actions taken. A State Resource Group of 16 experts trained as master trainers/mentors made 71 supportive supervisory/mentoring visits to 33 health facilities, community health centers (CHCs), and sub centers (SCs) varying from one to four visits/facility. Data from first visit was compared with last visit. Results: Though the implementation period was short to see significant impact, there was a gradual improvement in systems, demonstrated by timely updating of Health Monitoring Information Systems data (27% to 91%); availability of emergency contraceptive pills (18% to 55%), intrauterine devices (82% to 100%), and non-scalpel vasectomy kits (73% to 82%); and availability of doctors trained in clinical FP services (64% to 73%) at CHCs. Demand generation improved at CHCs, as did availability of hand-outs for clients (0% to 36%), and use of tools for counselling (7% to 27%). Utilization of unspent budget increased. Attitudes towards information sharing and joint problem solving improved. The state government adapted this tool for all health programs, added five regional coordinators, and budgeted for supportive supervision in 2013-2014. Conclusion: Empowered health managers with the right information and tools for management capacity and capacity to use data in supervisory visits & can move policies quickly into action, facilitating improvements in systems performance.
Using cellphones to get patient feedback on health service provision in South Africa

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ABSTRACT

Purpose Using cellphones, patients are provided the opportunity to rate their experiences of public health care facilities. This data is used by the Office of Health Standards Compliance (OHSC) to improve facility standards over time. Focus/content Cell-Life was funded by the EU to work with the new South African OHSC in designing a cellphone-based rating system for public health facility users. At present the OHSC relies on periodic patient surveys to collect such data: the ‘Rate My Clinic’ service allows for both timely and consistent feedback to the OHSC. Users are asked to rate their experiences according to the 6 key areas of concern for the OHSC. Each facility is assigned a code that is advertised on-site and included as part of the cellphone log-in to the service. Real-time data on facility, district and provincial scores for each area are accessible to the OHSC on a secure website. The service is currently being piloted with the collaboration of community-based organizations, so to monitor the ability of the service to reflect community composition and gather information on any utilization patterns. Significance to field Responsiveness to public facility users’ concerns is a key issue for the South African National Department of Health and the OHSC. Utilizing patient cellphones improves anonymity and bypasses issues with traditional means of gathering user feedback such as putting paper forms into a suggestion bin or asking to speak to a supervisor. The service focuses on providing the OHSC with the ability to track trends over time (not monitor individual complaints). To the best of our knowledge, there is no equivalent service available worldwide. Target audience Public health facility users, Office of Health Standards Compliance
Community action for health- Community led evidence collection, planning and action to strengthen public health system

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ABSTRACT

Introduction: The Community Action for Health (CAH) process democratically expanded and strengthened Village Health Water Sanitation and Nutrition Committees (VHWSNC) as per national guidelines and supported by government, to enhance community knowledge on health rights, roles, responsibilities and trained in community led health monitoring and planning. This also motivated community in leading action on identified gaps and evolve people centered health system. This paper aims to present findings from three rounds of monitoring data and community felt realities about health system and community led action after monitoring and planning. Methodology: Data was collected through a pictorial tool that was evolved in participatory way. In 3700 villages, three rounds of monitoring were done on eight health services followed by planning and community led action. Monthly VHWSNC meetings were facilitated to ensure follow up (described earlier in Beijing HSR). Data collected from different caste groups and geographical locations to capture inequity based on accessibility, social exclusion and disadvantaged. It was transferred to central server using cost effective SMS technology. Findings: Community collated the village data at village clusters as health report card using traffic light color codes, to prepare health action plan. It also aided Primary Health Centre (PHC) to prepare action plan with stake holder participation. CAH described innovative measures such as Availability-Quality-Education index to present and advocate findings at various tier levels with the government for health system strengthening. Health system used this data for triangulation and to prepare Project Implementation Plan. VHWSNC took initiatives to address social determinants of health and strengthen service delivery of peripheral health workers based on health action plan. Conclusion: This community centered evidence collection process not only showed potential to trigger community led action to strengthen health systems, but also generated data that could be effectively used to further strengthen health system in multiple dimensions. Thus CAH emerges as an innovative way of health system strengthening on health rights and community participation.
Development of national norms and standards for benchmarking and monitoring pharmaceutical service delivery in nine provinces, South Africa

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ABSTRACT

Background The National Health Act 61 of 2003 makes provision for the National Health Council (NHC) to provide a framework for a uniform health system within the country. As part of this policy oversight, the need for a systematic method for assessing efficiency of pharmaceutical service provision to support patient care was identified. In October 2013, the South African National Department of Health's (NDoH) Chief Directorate: Sector-Wide Procurement embarked on an initiative to establish a set of minimum requirements (norms and standards) against which provincial pharmaceutical services could be routinely monitored using a peer review process.

Methodology

Four domains which play a key role in supporting service delivery, namely pharmaceutical and therapeutics committees, financial management, medicine supply management, and human resource management were identified. In November 2013, draft norms and standards were defined at input, process, output and outcome levels. Data elements for tracking progress towards achieving the standards were drafted. A participatory process involving senior management from NDoH, technical advisors and provincial heads of pharmaceutical services was used. Reporting templates were developed. Results By the end of December 2013, two quarterly reporting cycles had been completed. The first set of reports were structured into a dashboard and presented to the NHC which comprises the National Minister of Health, Deputy Minister and members of the Executive Council. Notable improvements were observed in provincial performance from quarter to quarter. Sharing of best practices across provinces was also evident.

Discussion and Conclusion

The negotiated approach has allowed refinement of the norms and standards which have support from key role players. The use of the norms and standards to assess provincial performance has provided a framework to assess the efficiency of the provision of pharmaceutical services. Governance, financial management and supply chain management are being strengthened and accountability improved.
Using peer assessment to assess and improve health system emergency response

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ABSTRACT

Effectively responding to health emergencies—including disasters, disease outbreaks, and humanitarian emergencies—requires the concerted and coordinated effort of complex people-centered health systems that include public health agencies, health care delivery organizations, public- and private-sector entities responsible for public safety and education, employers and other organizations, as well as individuals and families. The complexity of these people-centered systems, coupled with the singular nature of health emergencies (each differs in the nature of the threat, the capabilities of the responding agencies, as well as the context in which it occurs) creates challenges for determining which approaches are most effective, and, more generally, for organizational learning. Given these circumstances, new methods that draw on the expertise of the people involved in leading the response are needed to generate systematic and rigorous knowledge to improve the quality of the health sector response to emergencies. One means of addressing these challenges is a 'peer assessment' approach to learning collaboratively from singular events. This presentation will describe a process, drawing on realist evaluation, root-cause analysis, and other social science methods, in which peers from similar jurisdictions work with representatives of the health system organizations 'broadly defined' that responded to an emergency event to identify lessons for improving future responses. Field tests and the views of the health professionals who participated in the process suggest that this peer-assessment approach is feasible and leads to a more in-depth analyses than standard methods. The involvement of peers from other jurisdictions improves objectivity, helping to generate systematic and rigorous knowledge of effective system responses. Engaging people involved in operating emergency health systems capitalizes on their professional expertise and also provides an opportunity to identify best practices and transfer them to other systems.
Improving nutrition of infants and children at the bottom of the pyramid: an innovative market-based approach to deliver a complementary food supplement in Eastern Ghana

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ABSTRACT

The project utilized a market-based approach to deliver a complementary food supplement (Koko Plus) to infants and young children in three districts in Eastern Ghana. Key elements of the design included: - A formative assessment to understand the emotional triggers were used to inform the marketing strategy and communication campaign; - A community leadership advocacy campaign involved engagement with local opinion leaders, influencers and stakeholders at all levels to generate buy in; - A range of message delivery platforms used to engage a broad audience, such as community radio, interventions at health facilities, cooking demonstrations and market day activities. Throughout the project, we adapted strategies to ensure that the project responded to the needs of the local environments. The Global Alliance for Improved Nutrition (GAIN) and the University of Ghana (UG) are conducting an independent evaluation to assess coverage and barriers to coverage. The first assessment was conducted two months into the project. Early results showed 64% of those surveyed had ever heard about the product, 23% report ever using the supplement, and 15% reported using the supplement within the previous week. Findings were reported back to the program within two weeks of survey completion to provide a quick feedback loop to guide programming efforts. An end line survey is planned for May 2014. This project has used an innovative, evidence based approach to effectively address undernutrition in infants and children by increasing access and utilization of a complementary food supplement. A critical element for success is that the project was centred on people and responded to their desire to provide for their children. This is a model that has relevance for other institutions aiming to improve the nutrition and livelihoods at the bottom of the pyramid. Future scale-up of the program to additional districts in Ghana is in the planning phases.
Garbage in, garbage out: How basic tools and attainable two-way communication can promote more dependable health systems data

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ABSTRACT
Quality of central-level health system data is dependent upon the quality of data input and upward reporting from lower levels; errors and delays in data entry and consolidation at lower levels trickle upward, calling into question the reliability of aggregated data. This presentation discusses the potential for big gains in data quality within the health sector in Mozambique through the use of basic but effective tools and regular two-way communication. The Retroinformação ('retro information') process uses a basic but effective Excel-based tool to monitor the timeliness and completeness of health information system reports submitted by Mozambican provinces to the Ministry of Health. The tool also collects data on the coverage of health interventions for maternal child health, HIV and malaria over time. At the end of each month, the National Department of Health Information discusses reporting compliance and achievement against targets with provinces. Though this type of feedback existed previously, it was neither systematic nor easily replicable. As a result of this process, timeliness of data submission improved in all provinces; completeness remains a challenge although provinces are taking action to collect missing data and correct inaccurate entries. Compliance improved from a 31% baseline in 2012 to 47% as of December 2013, a staggering 52% improvement. A new tool has been recently introduced that will quantify Retroinformação impact in terms of completeness of information. The two tools will be integrated in newly developed HMIS software based on DHIS2 technology. Since the quality of a health information system is only as good as its data inputs, participatory, two-way channels like Retroinformação play an instrumental role in feeding people-centered health policy and research. When health systems are empowered by dependable data, they are more able to sustain quality information flows that promote informed policy development and systems strengthening.
Rapid routes to scale: Exploring the scalability of innovative primary care models in low- and middle-income countries

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ABSTRACT

Improving primary care delivery is critical for increasing access to quality health services and medicines and in the developing world. Primary care involves long-term patient-focused care through comprehensive provision of preventive and basic health services. This study aims to identify and analyze how innovative private primary care models scale to extend the reach of health services and increase health impact in low- and middle-income countries (LMICs). We conducted a review of the peer-reviewed and grey literature on primary care, innovation, scale up and performance in LMICs. This review informed the development of criteria to filter 400+ primary care programs in the Center for Health Market Innovations database. Programs were selected based on meeting definitions of primary care, evidence of impact and scaling up. The resulting subset of 52 programs were further evaluated, and three were selected for case studies involving field visits and in-depth interviews to assess their strategies and models for scaling up. The study identified a number of innovative and effective primary care models that have scaled or demonstrate a potential to scale up. Private primary care models able to scale are typically characterized by partnerships with the public sector and local community, innovative use of information communication technology, effective leadership, financial sustainability, and robust human resources capacity. Strategies involving local adaptation of service delivery and integration and coordination of offerings with other providers proved most effective for scale up. Comprehensive and accessible primary care plays an important role in improving the health of the poor in developing countries. We need to identify and support the scale up of effective models to increase their impact for LMIC populations. This study identifies scalable primary care models and provides tools for recognizing and overcoming barriers to scale up in the health care ecosystem.
Evaluating nursing education: Applying Kirkpatrick's four levels for evaluating option B+ training programs implemented through the Nursing Education Partnership Initiative (NEPI)

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ABSTRACT

Purpose Nursing education strengthening is a strategic approach to producing and maintaining a skilled nursing workforce, a critical component of an effective health system. Nursing education program evaluation often falls short by focusing solely on immediate learner satisfaction and achievement of course learning objectives, rather than additionally measuring longer term job performance and effects on the health system. In response, the ICAP-Columbia University Coordinating Center for the PEPFAR-funded Nursing Education Partnership Initiative (NEPI) developed a strategy based on Kirkpatrick's four-level evaluation model to evaluate the ICAP Option B+ pre-service nursing curriculum for prevention of mother-to-child transmission of HIV. We provide methods and measures to evaluate the effect of nursing education strengthening on the nursing health workforce and ultimately on country health systems. Focus/Content Using Kirkpatrick’s model we developed 1) online post-training surveys to measure learner satisfaction (Level 1 - Reaction); 2) online pre-post case-based multiple choice tests and behavioral skills checklists to measure achievement of learning objectives (Level 2 - Learning); 3) job performance checklists to compare actual performance to expected performance (Level 3 - Behavior); and 4) an organizational assessment instrument to assess the multi-dimensional process of learning and behavior change diffusion through health organizations/systems (Level 4 - Results). The methods and measures will be pilot-tested in Lesotho, Malawi and Zambia in evaluating the ICAP Option B+ pre-service nursing curriculum for prevention of mother-to-child transmission of HIV, which includes an online module, classroom learning, clinical simulation, and a clinical practicum. Significance for Selected Field-Building Dimension Nursing education strengthening is critical to building health systems and achieving global health-related goals and objectives. Nursing education program evaluation should also examine job performance and organizational/systems level improvements. The evaluation model used expands on traditional nursing education evaluation by introducing methods to comprehensively measure and improve the effectiveness of nursing education programs.
An innovative central chronic medicines dispensing and distribution unit for public sector patients

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ABSTRACT

Purpose: In the last decade the universal access to Antiretroviral Therapy (ART) coupled with the burgeoning of non-communicable diseases (NCDs) has increased the need for chronic medication in South Africa. This has resulted in an over extension of public sector health care facilities, stock outs, long queues and declining quality of care. Subsequent impacts have been poor adherence to medication and excessively high pharmacy personnel-to-patient ratios. As a result, the National Department of Health (NDoH) involved the private sector and provided three Central Chronic Medicines Dispensing and Distribution (CCMDD) service providers in 8 provinces (excluding Western Cape). Focus / content: Facilities identify stable patients on chronic medication; give them an option to enrol in the programme. A patient is then registered, first script dispensed at the facility, a repeat script for 5 months submitted to CCMDD who pick and dispense individual patient packs and deliver every 28 days to identified pick-up-point (PUP). The patient is notified via short message service of medicines delivered to pick-up-point. Contracted service providers serve as designated PUP for the public sector chronic medication. The contractor receives patient packs with medicine in a dispensed format ready to be handed over to the patient. The creation of this innovative model provides essential medicines to people requiring long term medication. The model is people-centered as it places the patient at the pivot of the system. Significance: Results will be available for analysis in the next 6 months. The facilities have been identified, the number of ART patients who are stable have been identified, road shows and social mobilisation has taken place to encourage users. List of preferred PUPs were drawn up with the development of a monitoring and evaluation plan and a client satisfaction survey. All of these should elicit key information to assess the efficacy of this system. This results directly in a strengthening of the health system.
The health system analysis: an analytical review of health systems strengthening interventions to address bottlenecks, measure health outcomes and document the estimated contribution to long-term health impact

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ABSTRACT

As health programs and initiatives implemented in low- and middle-income countries (LMICs) invest significant resources for bringing better value-for-money approaches to attain health outcomes and impact, it is imperative to fully understand the complexity and dynamics of the health system and its many inter-related components that health programs and initiatives aim to strengthen. The health system analysis (HSA) is a systematic approach to review health system components and provide implementers, health policy makers and donors data-informed options to make smart management decisions for addressing systemic challenges and maximize the achievement of health impact. The HSA uses a stepwise approach to review the epidemiology, health policy framework and the investment of stakeholders to determine how to best improve effective coverage rates at the population level and how to address health systems components in order to improve performance, achieve health outcomes, and contribute to long-term health impact. The HSA was developed based on years of on-the-ground experience strengthening health systems in LMICs through horizontal and vertical approaches for improving health system performance at various levels (community, district, regional, and central). In addition, the HSA has adapted approaches developed by the seminal work of WHO and ongoing work of UNICEF on the analysis of health service coverage and its evaluation. Finally, the HSA has used to date two modeling tools (Spectrum and Impact-2) for quantifying prospectively and retrospectively the estimated contribution of health programs towards long-term health impact. This session will provide results from health system analyses recently conducted in four countries: Democratic Republic of Congo, Ethiopia, Haiti, and Uganda. Findings of the analyses reveal how health programs, individually and collectively, are strengthening different health systems components within their respective scopes of work with similar interventions but delivered under different context with a variety of management inputs for various health systems building blocks.
So you have your WISN calculations, what's next? Using cost data to evaluate HRH policy options to meet the WISN required staffing levels.

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ABSTRACT

Background: The Workload Indicators of Staffing Needs (WISN) methodology was developed over 15 years ago by the WHO as a human resources management and planning tool. USAID assisted the Republic of Namibia in the application of the WISN methodology nationally for the doctor, nurse, and pharmacy cadres in hospitals, health centers, and clinics. While the findings documented HRH shortages and inequities across regions and facilities questions remained on how to address them. Namibia faces a narrow financial and HRH pipeline to meet its needs. A range of policy options were proposed to alleviate staffing shortfalls and workload pressure. This study evaluated the budgetary implications of these policy options. Methods: Three policy options were selected for this analysis: 1) Increasing the number of staff to meet the WISN staffing requirements; 2) Redistributing existing staff; 3) Reallocating tasks between different staff cadres. Results: Of the three policy options considered in this analysis, the most costly would be increasing the number of staff posts to meet the WISN staffing requirements. However, by first redistributing staff within the same region before increasing the number of staff posts requirements, costs of implementation are reduced by 17 percent. Task shifting from doctors to nurses or similarly from a nurse to clinical support staff would result in a further decrease in costs. The severe shortage of doctors and the higher cost of salaries for this cadre means that by shifting some of their tasks to nurses, fewer doctors would be required, partly filling the staff deficit for this cadre while also reducing overall staff costs. Discussion/Conclusion: The WISN methodology provides the initial evidence for decision-makers. A rigorous costing analysis of policy options takes the WISN analysis to the next level. The policy options examined in this study will likely be relevant for other countries facing HRH shortages and inequities.
Using mixed methods to assess scalability and sustainability of supply-chain innovations: lessons from the Supply Chain For Community Case Management (SC4CCM) project

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ABSTRACT

Background SC4CCM is a learning project with the goal of increasing availability of essential medicines to treat sick children at community level. Supply-chain innovations implemented in three countries (Rwanda, Malawi, and Ethiopia) were assessed for positive effects before initiating scale-up plans. The endline evaluations provide evidence on two central concepts: scalability and sustainability of the proven innovations.

Purpose SC4CCM used two cross-cutting principles: 1) maximize affordability and feasibility of implementation through innovation design; 2) implement to facilitate absorption by the existing SCM system. The endline evaluation assessed: 1) breadth and depth of scale-up; 2) extent to which midline effects were maintained; 3) extent of institutionalization; 4) how the two guiding SC4CCM principles contributed to scale-up and likelihood of sustainability. Focus/Content Program theories form the foundation of the mixed-methods evaluation design. Quantitative data are comparable to midline, providing ex-post comparisons and indicators for qualitative findings. The qualitative component informs understanding of relationships among scalability, institutionalization, integration and sustainability, especially feedback loops and non-linear pathways.

Significance We want to know how to achieve impact at scale, when desired impact of interventions has been detected. Often, to maximize effects of interventions, the intensity of inputs can reduce the likelihood of sustainability and scale-up. The SC4CCM project balanced these tensions from the beginning, pursuing intervention designs that would contribute to scale-up and sustainability. Yet, SC4CCM also demonstrated positive effects at midline. This study provides evidence on how this was achieved, and illustrates a mixed methods evaluation approach that can be applied to other interventions to better understand and document scalability and sustainability. Target Audience Those interested in systematically assessing scalability and sustainability of interventions, and what project approaches can contribute. Evaluators interested in mixed methods evaluations that gather evidence from multiple implementation contexts and seek to synthesize findings.
Using evaluation results to inform realistic goal setting in health system strengthening: The integrated health program in the Democratic Republic of Congo

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ABSTRACT

Integrated Health Program (IHP) is a five-year USAID-funded project that supports the Democratic Republic of Congo’s National Health Development Program (PNDS). IHP aims to create and support an enabling environment for high-impact health services, products, and practices in eighty target health zones (HZ) within four provinces. Baseline (2011) and intermediate (2013) evaluation studies provided benchmark data on (a) access and availability of key family health services at public health facilities (minimum package of activities: MPA-plus); (b) health service delivery management capacity (supply-side); and (c) community knowledge, attitudes, and practices of family care service-seeking behaviors (demand-side). Additionally, IHP performance and outcomes will be evaluated at the end of the program (2015). The innovative supply-side evaluation used the Magpi mobile health data collection system in remote, fragile settings for a cross-sectional survey of 96 health facilities in 23 randomly selected HZs and 383 client exit interviews with pregnant women, those of reproductive-age, and mothers of children aged 0-23 months. Key informant interviews were conducted with health providers, Ministry of Public Health staff at the national, provincial, district, and HZ levels, and members of Community Health Development Committees. The results were triangulated with the baseline household survey. Evaluation results indicated that it was unrealistic to expect 80% of IHP’s health facilities to achieve a full range of MPA-plus services by the end of the project: the breadth of the target population (total ~1,600 facilities) and the depth of MPA-plus services (~50 activities) were overly ambitious given the health system’s existing status, logistic constraints, and implementation costs. IHP project priorities and targets (including depth of the MPA-plus package and design interventions) were revised to better reflect the epidemiology and most pressing self-identified needs of the populations served. In addition, priorities for scaling up of health sector leadership and governance were identified and incorporated.
Capacity, performance, and data: Using the CYPRESS Methodology to research and validate people-centered capacity building approaches in health systems

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ABSTRACT
This presentation for practitioners and donors introduces Deloitte’s CYPRESS Methodology, a strategy for engaging counterparts to lead capacity building in health systems while generating data to research and validate people-centered approaches and policy development. CYPRESS is a five-step methodology that places local ownership and performance management at its core. With CYPRESS, the counterpart is responsible for setting targets, assessing performance gaps, designing and implementing targeted interventions to close those gaps, and measuring changes in performance. Tailored approaches and a central focus on counterpart empowerment set CYPRESS apart from other capacity-building approaches, many of which succeed in the short-term but fail to generate long-term results or systemic insight. Further, each step of the process includes actions and outputs related to data. The data outputs not only measure change and performance of the counterpart, but when compiled and compared with data from other CYPRESS implementations, can contribute to a global view of what works in local institutional capacity development. As a result of CYPRESS implementation, counterparts have achieved measurable results: over 70,000 reached with HIV prevention services; over $800,000 in new funding mobilized; and increased team-building, country ownership, and staff mobilization. Data collected demonstrates these individual successes. Concurrently, a commitment to aggregation and analysis of data across countries acts as a research-based approach to capacity development of health systems. The data collected throughout CYPRESS implementation is dual-purpose: it enables counterparts to make informed, evidence-based decisions about their own operations and performance improvement, and it contributes to a broader evidence base that can be used for people-centered health policy and systems research. Armed with the data collected during CYPRESS implementation, we can derive insight about organization-specific improvements and trends across networks, as well as identify findings about the broader systems in which they operate.
Integrated community case management in practice: lessons learned from a participatory evaluation in 3 African countries

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ABSTRACT

Background Despite numerous studies highlighting the effectiveness of an integrated community case management approach, there is little data on implementation in practice and stakeholder experiences of Integrated Community Case Management (iCCM). This participatory evaluation documents lessons learned and explores iCCM implementation experiences across three African countries: South Sudan, Uganda and Zambia. Methods Qualitative methods used for data collection across the three countries included stakeholder consultations (key informant interviews, focus group discussions), and a review of documentation. Data analysis followed the content analysis approach; prominent themes were identified and used to assemble a thematic framework under which data was coded and sorted. Each thematic area was compared between target groups and contextualised, and associations between themes identified. Findings were then explained and interpreted. Data collection was conducted from November 2012 to March 2013. Results Overarching key programmatic themes and recommendations of relevance for further implementation or scale up included: collaboration with implementing partners in planning stages to positively impact on community acceptance and ownership; adoption of participatory training methods adapted to local context; development of alternative supportive supervision methods such as peer support groups; full integration of community level data into Health Management Information Systems; strengthened supply chains through improved quantification and procurement of commodities in conjunction with the national distribution network; community engagement to establish support systems for Community Health Workers to increase their motivation; enhanced sensitisation and behaviour change communication focus to raise awareness and usage of appropriate health services; and advocacy at national level for funding and logistical support for continuation and integration of iCCM. Discussion This participatory evaluation provides a valuable insight into the various perspectives of a range of stakeholders involved in the introduction of iCCM programmes, including the communities being served. The context-specific learnings from this research can greatly inform policy-makers in scaling-up iCCM programmes.
Strengthening the vital registration system in Ghana: Evidence, practice & lessons learned from a community based approach in Northern Ghana

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ABSTRACT

Background: National Civil Registration and Vital Statistics (CRVS) systems are considered the most sustainable way to track fertility and mortality trends. Full pregnancy histories are the current best practice tool for measuring under-five mortality and fertility rates in contexts with weak vital registration. While there is growing recognition that community-based health workers (CBHWs) can enhance collection of essential information in rural areas, there is limited evaluation of the accuracy and completeness of these systems in recording vital events. Methods: In collaboration with Ghana’s Births and Deaths Registry (BDR), we trained 120 community-based volunteers (CBVs) to track, report and help register vital events in Ghana’s Northern Region in order to produce more frequent and local mortality estimates and improve registration of vital events. The completeness and accuracy of the longitudinal collection of events was assessed against a full-pregnancy history (FPH) census of 6,900 households after 21 months. In addition, barriers and routine vital event registration practices were explored among community members. Results: The CBV method under-reports on under-five deaths but captures almost all births, which underestimates the under-five mortality rate. Migration plays an important role in assessing the accuracy of this community-based CRVS system. Nearly all the neonatal deaths reported by the CBVs occurred during the early neonatal period. Conclusions: Using CBHWs as avenues to formal birth registration can substantially increase rural birth registration rates, but the effort required to ensure high quality data should not be undervalued. Additional studies are needed to understand why CBHWs under-report on under-five deaths and how to improve mortality estimates coming from such approaches. Further efforts to link CBHWs to formal registration processes are required to improve global registration rates, but working with such government structures introduces additional challenges. Understanding how migration impacts mortality estimation in non-nationally representative studies needs further exploration.
Understanding the productivity and performance of community health volunteers and what affects it: Cross-sectional study of village health teams in Uganda

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ABSTRACT

Background: The importance of Community Health Volunteers (CHVs) and Community Health Workers (CHWs) has garnered increasing attention from governments, donors, health systems researchers and planners. In Uganda, Village Health Teams (VHTs) are made up of village volunteers who are responsible for promoting health and linking community members to care as part of their daily activities - they form the lowest level of the health system. If CHVs are to contribute effectively to community-based programs, it is critical to understand how well they do their work against expected standards (performance), how much they can feasibly do (output), and what factors affect their work in order to deploy and support them to do their work as effectively and productively as possible. This study sought to explore the factors that influence productivity and performance and the relationship between productivity and performance. Methods: This study employed a cross-sectional quantitative design to assess VHT productivity and performance and explore factors affecting these for the basic package of services VHTs provide. The study population included all 162 VHT members in two randomly selected sub-counties of the Busia District in eastern Uganda. Observational, record review, and interview data collection methods were used. Data are being analyzed using a modified World Bank Productivity analysis method, Principal Components Analysis, cluster analysis, and descriptive and comparative analysis. Results: Data have been entered into a database from all 162 VHTs. The data will be cleaned, coded and prepared for analysis with the findings ready by April 2014 and formally presented for the first time in Cape Town. Discussion/conclusion: While many studies have explored factors (e.g., CHV or CHW factors, support factors, environmental factors, client factors) that may influence CHV performance, none have examined the interplay of factors that can affect both productivity and performance.
The provision of TB and HIV/AIDS treatment support by lay health workers in South Africa: A time-and-motion study

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ABSTRACT

Background Lay or community health workers (LHWs) can bridge communities and the health system and improve primary healthcare access. Their optimal use is often hampered by a poor understanding of how they organise their work. This study explored the activities undertaken by LHWs, and the time spent on these, in providing adherence support to people on TB treatment and/or anti-retroviral therapy (ART) in South Africa.

Methods Fourteen LHWs across three low-income communities in Cape Town participated. For each LHW, observational data was collected on each activity and the time spent on it for one day. Data were summarised into: travel to the patient's home, waiting time and patient contact time.

Results 97 attempted patient-visits were observed and patients were located in 69 visits. On average, LHWs conducted 6 visits per day lasting, on average, 9 minutes. 46% of the observed time was spent with patients, with the balance spent on walking to, and waiting for, patients. The average walking time between patients was 8 minutes (range: 3 - 15 minutes). Activities during visits comprised medical care (ensuring that medication was being taken correctly and monitoring side effects); social support; assessments of barriers to treatment adherence; and tracing patients who had defaulted from treatment.

Conclusions Because of their tasks and working environment, LHWs providing support to people on TB treatment and ART in South Africa spend a substantial proportion of their time on 'non-contact' activities, such as waiting for patients. Programme managers need to take this into account when determining patient caseloads for this cadre, planning the scale-up of LHW programmes and considering whether community-based care can be sustained where human resources are limited. More work is needed on the use of new technologies, such as mobile phones, that may mitigate the challenges that LHWs experience in locating and supporting patients.
Systemic convergence for addressing undernutrition: lessons for India's new multi-sectoral nutrition programme

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ABSTRACT

Background: India launched the multi-sectoral nutrition programme in January 2014 with the aim of bringing about convergence and inter-departmental collaboration at all levels of governance to address child undernutrition. The aim of this paper is to highlight the significance of convergence in bringing about community participation, improved service delivery, and accountability of public systems through innovative community-based strategies for improving nutrition in poor populations. The paper draws on experience of community-based innovations in health-nutrition programming in the resource-poor state of Chhattisgarh.

Methods: The primary method was difference of means of data from facility-surveys to compare the outcomes in interventions clusters with non-intervention clusters through propensity score matching techniques. This was supplemented by qualitative data from document analysis, interviews, and group-discussions. Results: Statistically significant differences in outcome indicators in intervention-clusters were seen - 13.7% improvement in community participation and monitoring of government programs; 19.6% increase in community awareness about public programs; improvement in service-delivery and access to public programs in 96% cases; 20.3% improvement in service quality; increased human resource convergence through meetings in 67.9% clusters with all 3 frontline workers. Analysis of qualitative data indicates that innovative community-based strategies are important to implement the idea of convergence, especially in contexts that do not have historical experience of such partnerships. Convergence also contributed towards improved participation of communities in self governance, community monitoring of government programs, and therefore, better services. Discussion: As the Indian government rolls-out its ambitious agenda of multi-sectoral convergence, lessons from within the country, especially from resource constrained areas, can provide valuable direction. Integration can affect decentralization of power, inclusion of poor communities, and efficiency, accountability and improved service quality in government programs. The community-based innovations detailed in this study can provide models for replication in other similar contexts for translating and sustaining the idea of multi-sectoral convergence.
The impact of the Bono Juana Azurduy: an incentives-based program to achieve universal access to maternal and child health in Bolivia

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ABSTRACT

Background: In response to still high levels of infant mortality and child malnutrition, the Government of Bolivia established in 2009 a nation-wide cash transfer program, the Bono Juana Azurduy (BJA), to encourage the use of maternal and child health services. The program was innovative by giving a central role to community health workers in the enrollment and monitoring of conditionalities. Methods: Our study aims to assess the effectiveness of the BJA in increasing the utilization of health services by pregnant women and children and in improving their health and nutritional status. The impact identification strategy is based on comparing differences in health outcomes of siblings that were eligible and not eligible to the program between participating and not participating households. Impact coefficients were estimated using family fixed effects models. Results: We found consistent positive effects of the BJA on the use of antenatal care services, including early pregnancy detection and completing at least 4 antenatal care visits. The study shows evidence that this in turn had an effect in child health by reducing the probability of low birth weight. There is also an increase in the probability of skilled birth attendance, although this result is evident only in rural areas. In contrast, we observe no evidence of an impact on nutritional outcomes like chronic malnutrition or anemia. Conclusion: Based on our results, we conclude that the BJA program has been an effective incentives-based model for increasing the use of community health services in Bolivia and fostering the interaction of pregnant women and children with the health system. However, we argue that aspects related to the supply side of service delivery, including better quality of care and responsiveness of the health system, are of fundamental importance in order to achieve impacts in final health and nutrition outcomes.
Analysing the Health outcomes with village level institutions as catalysts in the State of Andhra Pradesh, India

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ABSTRACT

Background Impact of safe water, sanitation and hygiene on health outcomes has been amply demonstrated world over and recognized as important social determinants of health among others. It has been reported that almost one-tenth of global burden of disease can be attributed to water, sanitation and hygiene issues. 65% of rural areas in India are without proper sanitation facilities and acute water shortage is faced by large part of the country. Purpose and Focus Given the above background, this paper studies the association between implementation of safe drinking water and sanitation programs and the health outcomes of families and communities in the villages covered under the state sponsored Nirmal Gram Puraskar (NGP) Program in one of the key districts of the state of Andhra Pradesh in south India. While analysing the various factors involved in the association of NGP and health outcomes, the paper lays special focus on the role of village-level institutions like the Village Water and Sanitation Committee (VWSC), Village Health and Sanitation Committee (VHSC) and Self Help Groups (SHGs). Health outcomes in the villages with NGP are compared with the open defecation (OD) villages not covered by NGP. It is hypothesized that a proactive role played by the village level institutions as envisaged by the National Rural Health Mission (NRHM), contributes to success of such people-centred health programs and brings about improved health outcomes for the individuals, families and communities. Methodology: Primary research based in Visakhapatnam district in Andhra Pradesh, India with data collected during field monitoring, stakeholder interview schedules supplemented by published, secondary data. Significance to Field-building Dimensions Experience of village communities engaged in strengthening health systems is analysed from community health perspective which is relevant and useful to future programs and associated research work.
Exploring progress in health through a multi-sectoral lens: lessons for the post-2015 agenda from case studies in maternal and child health and neglected tropical diseases

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ABSTRACT

Background As the MDGs draw to a close, there is increasing interest in learning from some of the leading performers: countries achieving progress in developing effective systems despite constraints. Questions remain on how to measure change and what alignment of factors help pave pathways to progress. While the WHO-promoted social determinants agenda emphasised the need for cross-sectoral analyses, little evidence exists using such a lens to assess health programmes and systems. OD’s Development Progress project takes a broader development approach to health systems analysis. Methods This study was informed by case studies in seven low-income countries (Bangladesh, Cambodia, Eritrea, Mozambique, Nepal, Rwanda, Sierra Leone) between 2010 and 2013, exploring progress in maternal, child health and neglected tropical diseases (NTDs) among marginalised populations. In-depth interviews (268) at national, district, and sub-district level were conducted. A semi-systematic review of literature (2000-2014) provided context and shaped the interpretation of findings. Results Cross-cutting themes emerging as facilitating progress include: strong leadership and sustained political commitment to prioritising primary health (in the health systems and other sectors), e.g. Bangladesh and Nepal; intra and inter-sectoral collaboration, building on existing programmes/infrastructure, which with private-public-partnerships, enabled cost-effective delivery, e.g. NTD control in Sierra Leone and Cambodia. In all countries bottom-up approaches and community participation to address staff shortages, access hard-to-reach populations, generate ownership, and empower women; and ongoing, predictable and aligned donor commitments were essential. Conclusion/discussion Findings show that a multi-sectoral approach to understanding progress critical, and factors explaining progress are located at micro (community/informal), meso (district/sub-national) and macro (national) levels, with inter-linkages across levels. With post-2015 discussions exploring gaps in the MDGs (e.g. inequality and social protection), these findings are timely and highlight that a silo approach - arguably a feature of the MDGs - focusing exclusively on the health system may no longer be appropriate.
Health on the move: Field observation and evaluation of community-based health projects in Afghanistan

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Brac Institute Of GL

ABSTRACT

The Taliban era devastated the health infrastructure and left health status in shambles in Afghanistan. Ban on female education at all levels and closure of midwifery schools left the country with fewer health care professionals creating adverse impact on health services. Deep rooted patriarchy, the harsh terrain, lack of accessible services resulted in health seeking delay which eventually led to early marriage with high rates of fertility and maternal mortality. BRAC (the largest NGO in the world) Afghanistan implemented Community Based Health Care Programs (CBHCP) to train female community health workers (CHWs) to improve MNCH services across different provinces of Afghanistan. BRAC targeted marginalized ultra poor segment of people in two underprivileged provinces. DAC (Development Assistance Committee) principles were used to assess CBHCP projects which included a comprehensive document review and interview with health providers and clients. The findings revealed that the number of CHW trained by BRAC reaching expected monthly target of training individuals. Majority of the trained CHWs remained active in the field activities. CHWs received refreshers training to improve the quality of health services at the household / community level. Average households visited per CHW achieved yearly target. Coverage of Contraceptive methods, Antenatal Care (ANC) and Postnatal Care (PNC) services greatly exceeded the yearly target. The coverage of immunization and distribution of oral saline had been remarkable in the community and case detection of TB and referral of patients for DOTS treatment by the CHWs had been consistently high. In conclusion, the BRAC's approach to strengthening of health services had been commendable through recruitment of mostly female staffs for the community health services, which seem to be effective in their service delivery strategies with wide recognition in the community and had been instrumental in raising the overall health status of Afghan women and children.
Count down to zero; role of mentor mothers/couples in achieving virtual elimination of mother to child transmission by 2015: TASO Mbale experience.

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ABSTRACT

Purpose: Mother to child HIV transmission (MTCT) remains the second major mode of HIV transmission in Uganda, and the main source of HIV infection to children below 5 years. In 2011, a Global Plan was developed to move towards eliminating new HIV infections among children by 2015 and keeping their mothers alive. However, follow up of mother-baby pairs and adherence remain a challenge. Use of mentor mothers/couples can play an important role in providing peer support to improve adherence and follow up among mothers and their children. Focus: Successful PMTCT implementation involves enrolling into and continuing care and treatment plan, taking medicines to prevent and treat opportunistic infections, safe delivery in a health facility, practicing safer infant feeding practices, infant check-ups & HIV testing at 6 weeks as well as after weaning, on-going education and counselling among others. In April 2013, 12 mentor mothers/couples who are HIV positive, were identified and trained by TASO Mbale and have been providing peer support during PMTCT clinics and follow of registered mothers - baby pairs since June 2013. Activities involved in are: patient education, proper client flow, mapping and follow-up of mother-baby pairs, peer counseling and food demonstration under observation by counselors and linkages officer. Lessons learnt: - Eighty one mother-baby pairs have been followed up - 265 mothers have been reached with PMTCT related information - Retention of mother - baby pairs has improved from 36.7% in April 2013 to 56% in December 2013. - There is continuous linkage of mother-baby pairs from community to health facilities for services - Two family support groups have been formed - There is greater involvement of people living with HIV (GIPA) and male in eMTCT Conclusions: Mentor mothers/couples if trained and supervised, provide a wide scope of HIV prevention beyond PMTCT to communities and provide a foundation for formation of family support groups which are important in eMTCT.
Lessons learned from the pilot class of Community Health Assistants (CHA) in Zambia: A process evaluation to inform national scale up of the CHA program

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ABSTRACT

Background: In August 2010 the Zambian Ministry of Health (MOH) launched a National Community Health Strategy that included Community Health Assistants (CHAs), paid MOH employees recruited from within their communities. In June 2012, the inaugural class of 307 CHA completed one year of training and deployed to their communities. This evaluation of the first 6 months of the CHA program at the health post (HP) and community levels was designed to strengthen existing processes and inform national scale-up. Methods: Within each purposively-selected province, one district and two HPs were randomly selected. Semi-structured qualitative interviews were conducted with stakeholders in the selected districts at two months and six months after CHA deployment. Key themes explored included district ownership, community acceptance, coordination with volunteer community health workers (CHWs), work environment, scope of work, and supervision. MAXQDA Version11 (Berlin, Germany) was used for coding and thematic data analysis. Results: A total of 75 interviews were conducted. Almost all CHAs had been welcomed by community members and CHWs. Early acceptance from the community may have sustained motivation, irrespective of challenges. All CHAs had begun activities, but not yet completed visits to all households on their map within 6 months. Due to high demand at the HPs, CHAs were unable to spend the target 80% of their time in the community. Other challenges included incomplete HP infrastructure, lack of adequate drugs and commodities, lack of accommodation, and delayed salaries. Moreover, districts did not conduct adequate supervisory visits or incorporate CHA program implementation into their action plans. Conclusion: Findings from this evaluation highlight strengths of the CHA pilot year in bringing healthcare closer to the home; however, several challenges were identified that will require action by the MOH as the CHA program is brought to scale.
ASHA 'By the people.... But for the people ?'

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ABSTRACT

India’s 9,00,000 strong woman community health worker programme (ASHA) across 31 states and union territories is now almost 7 years old. The ASHA is selected for every 1000 population by the community, resident in the community, trained to undertake the roles of a facilitator, mobilizer and community level care provider for primary health services. The evaluation of ASHA programme was done in sixteen states of India using the realistic methodology. Within each state, two districts were chosen based on performance of ASHA programme. Sample size for each district included: 100 ASHA’s, 600 service users, 25 ANMs, 100 AWW, and 100 local governance representatives (PRI). The evaluation shows that despite adequate representation of SC/ST and Minority community in ASHA selection and modest levels of identification of marginalized communities by ASHAs, her coverage was limited. On an average 71% of women who delivered in last six months and 63% in cases of children with illness in last one month reported access to ASHA’s services, leaving out 29-37% of potential beneficiaries. Of the beneficiaries who received services from ASHAs about 39-41% belonged to the SC/ST category while only 19% were from minority community. The limited coverage could be on account of reluctance of the marginalized community or geographic dispersion or ASHA herself being from a marginalised community with low acceptance in other sections of community. The evaluation concludes that representation of SC/ST and the population coverage are not issues in the programme, but social and geographic barriers restricting coverage leading to a significant minority who are not able to access ASHA’s services are problematic. Programmatic efforts need to go beyond training in technical content to building ASHA’s skills in overcoming social barriers and reaching every household.
The impact of stakeholder values and power relations on community-based health insurance coverage: Evidence from three Senegalese case studies

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ABSTRACT

Background: Continued low rates of enrolment in community-based health insurance (CBHI) suggest strategies proposed for scaling up have not been successfully implemented. This study aims to investigate whether a lack of systematic incorporation of social and political context into CBHI policy can help explain the lack of enrolment (population coverage) and limited benefit package (scope of coverage). The focus is on Senegal, where the government views CBHI as a key mechanism for achieving universal coverage. Methods: Three case studies constituting CBHI schemes were selected using specific criteria. Stakeholders were identified using purposive snowball sampling. Transcripts of qualitative interviews with 64 CBHI stakeholders were analysed in Nvivo using inductive coding. Results: The five most important and interlinked themes pertaining to social values and power relations were voluntarism, trust, solidarity, political engagement and social movements. The analysis raises a number of previously overlooked policy and implementation challenges. The first is the need to remunerate CBHI scheme staff while retaining the perceived benefits of voluntarism such as fighting poverty, increasing solidarity and promoting trust. The second is developing a strategic approach to building trust in CBHI, for example by integrating CBHI schemes into community associations. Third is the challenge of subsiding premiums for the poor whilst protecting schemes from local political power struggles. Finally, there was a need to support schemes in federating with other CBHI schemes and other types of NGOs in order to facilitate collection of premiums and improve contracting health service providers, governance, training and technical assistance. Discussion/conclusion: Systematically addressing all these challenges would represent a fundamental reform of the current CBHI model promoted in Senegal and in Africa more widely. From a methodological perspective, studying values and power relations among stakeholders in multiple case studies can be an important complement to traditional health systems and health economics analysis.
Linking communities to care

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ABSTRACT

Background Mother to child transmission (MTCT) of HIV results in 700 children being infected every day. Increasing prevention of mother to child transmission (PMTCT or eMTCT) services coverage will reduce this number further in the future, but there are limits to health sector interventions that do not have community input. Description The Positive Action for Children Fund (PACF) launched in March 2010 supports 140 grantees in 30 countries. In order for community based organisations (CBOs) to be successful at supporting health responses around eMTCT, they need to be able to enter into a partnership with their local health service provider (clinic, hospital, outreach facility) with an expertise to add and the ability to partner effectively. For the health system, the PACF has found, wants partners that will complement their existing services helping to plug gaps and optimise services. Lessons Learned In order to support local communities around eMTCT, the PACF had to develop a technical assistance (TA) programme in support of CBOs. The TA comprises organisational capacity building, subject matter knowledge in HIV and eMTCT and training on partnering. 85 PACF grantees are currently in the TA programme. 100% of PACF partners in the TA programme are currently partnered with their local health facilities addressing issues such as loss to follow-up and EID. As a result of PACF partnerships 401,888 people have been reached with prevention activities and 118,241 have been driven into the health system for PMTCT services. Discussion CBOs are an essential partner in addressing eMTCT. They do not always have the skills and expertise to work with local health services as equals and targeting specific areas of need where their unique skills can be put to best use. TA is therefore as important as grant funding to ensure that eMTCT responses are optimised.
Football and better health - An evaluation of Deportes Para La Vida, an HIV education, prevention and leadership program for at-risk youth in the Dominican Republic

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ABSTRACT

BACKGROUND The NGO Dominican Republic Education and Mentoring (DREAM) Project runs many educational programs in the Dominican Republic. Since 2005, they have established and run an innovative HIV prevention, education, and leadership program known as Deportes Para La Vida (DPV). Geared towards underprivileged and underserved Dominican youth, the program uses sports activities to teach sexual health to its students. We conducted an evaluation study of this program between May and August of 2013.

METHODS Our study design was an intervention-control study, surveying students that had participated in DPV (intervention) and those that had not (control). Ages of participants ranged from 10-26 years of age. We conducted surveys during 13 site visits along the north coast using knowledge and practices surveys tailored from UNGASS-AIDS knowledge questionnaires and Centers for Disease Control and Prevention sexual health practice surveys. In total, 132 surveys were collected, 70 intervention participants and 62 control participants. Consent and assent were obtained and confirmed for all participants. RESULTS 39% of DPV graduates successfully answered all five questions, compared to only 10% of non-DPV participants. DPV graduates were 5.9 times more likely to answer all five questions correctly (P<0.001). Not one child in our control under the age of 19 was capable of answering all five questions correctly (n=50). 57 of our participants (43%) were sexually active, however no significant associations were identified within this group of individuals. CONCLUSION The 2012 national standard for HIV knowledge in the Dominican Republic shows that only 37.2% of the population has the necessary knowledge for AIDS risk factors. DPV serves as a strong tool for sexual health education within the country and succeeds as a worthy method of health risk communication. A greater pool of surveys will be necessary to elucidate exactly how the program affects practices.
The economic and health burden of ambulatory care sensitive hospitalisations in the Mexican health care system

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ABSTRACT

Background: Hospitalisations due to ambulatory care sensitive conditions (ACSCHs) have been widely used to study the access, quality and effectiveness of primary care services. In a previous analysis we showed that the national rate of ACSCHs in Mexico increased 50% in the period 2001-2011. This paper focuses on the economic impact that diabetes ACSCHs represent to public finance and sheds light on the preventable losses of health as consequence of ACSCHs, a topic that has not received attention in the literature. Methods: Hospital discharge records from general hospitals run by the 32 local health ministries are used to identify hospitalisations due to the main complications of diabetes (retinopathy, kidney failure, neuropathy, diabetic foot and amputation) between 2001 and 2011. The economic cost of each hospitalisation is estimated using inpatient day cost estimates and its length of stay. The estimation of the health cost assumes that patients would not have experienced complications if they had received appropriate primary care and computes the associated Disability-Adjusted Life Years (DALYs). Results: The national financial cost of treating avoidable diabetes complications in general hospitals during the studied period increased by 127% in real terms; when measured as cost per person without social security it grew from $8.06 MXN in 2001 to $15.87 MXN in 2011 [2011 Average Exchange Rate: $1USD = $12.42MXN]. The health burden of the selected diabetes complications in 2011 is estimated in 32,540 DALYs. The trends and magnitudes of these costs vary from state to state. Conclusion: Avoiding hospitalisations that could be prevented liberates resources within the health system and makes them available to their allocation for other health purposes. In addition, patients with ACSCHs suffer preventable losses of health that should be considered when assessing the performance of any primary care intervention.
Does intervention using various communication techniques reduce tobacco use in the community? 
An experience from a project in rural Bangladesh

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ABSTRACT

Background: Tobacco consumption is one of the leading causes of early deaths occurred in developing countries like Bangladesh. Bangladesh is on the verge of tobacco epidemic as 16% of total death among the people aged ≥30 years associated with tobacco. There are many difficulties to mitigate tobacco menace in Bangladesh despite public regulations. Community level effective communication strategy/techniques were largely absent to provide information about harmful effect of tobacco. icddr,b has developed a package of communication techniques to observe the reduction of tobacco use at the community level. Methodology: The project was implemented in Chakaria a rural sub district of Cox’s Bazar in Bangladesh where icddr,b active in research-development since 1994. Fifteen villages from three unions were selected for intervention and same were for comparison. We adopted various interventions as Othan Baithaks or household courtyard meetings; peer groups and video sessions; cell phone based SMS; counselling of smokers through mobile; involving village doctors in messages dissemination. Target audience was women and men aged ≥15 years. During intervention, female/male health worker showing/discussing the potential risks of smoking and dangers of passive smoking, emphasizing on the idea that smokers not only put themselves at risk but also do so to their families. Data collected from follow-up; mobile counselling; video sessions and process documentations were used for analyzing the results. Results: During January 2011-June 2103 intervention data total 9760 women/men aged ≥15 years from 1600 households participated in the Othan Baithaks and organized video-sessions. 78% of household were contacted for counseling through cell phones. Among targeted population 12% quit tobacco; 7.5% committed to quit and 15% reduce the use of tobacco compared to their daily intake. Discussion/conclusions: Community level communication techniques can be an effective way to combat tobacco menace along with public laws and regulations. The prevention strategies can be designed such a way that community can be engaged informed and creates their own platform.
ABSTRACT

Background: Despite recent attention to community-based primary health care (CBPHC), there remains a lack of rigorous evidence to evaluate the effectiveness of these programs. We summarize here strategies that have been used to implement community-based programs for improving neonatal and child health from a comprehensive review.

Methods: Over 4000 documents addressing CBPHC were identified in the published and gray literature. 476 reports qualified for inclusion in the review that demonstrated impact in reducing child mortality or severe morbidity. Two independent reviewers completed a data extraction form for each report, including information about the type of intervention(s) and the assessment procedures used. A third reviewer compared the two data extraction forms and resolved differences before entering in the database. Data were analysed using the STATA statistical package.

Results: Almost three-fourths of the programs, projects or research studies included in our review trained community health workers (72.9%), and more than one-third (36.3%) formed or supported community groups. More than half (56.2%) were involved in the promotion of partnerships between the community and the formal health system. A majority of reports (83.1%) described the use of a community mobilization or community empowerment strategy. Health system strengthening strategies were commonly mentioned (44.8%). Less commonly, innovative strategies for program design, identification of target groups, and surveillance were identified, as well innovative strategies for education of community-level health workers and of mothers. Very few projects (5.7%) included data sharing with the community, although slightly more (9.0%) reported that the community was highly involved in the evaluation of the program.

Conclusions: Future strategies for improving the effectiveness of health systems and programs in reducing neonatal and child mortality will require incorporation of the approaches identified in these effective programs and studies. In addition, effort should be made to encourage data sharing and usage with the community.
Follow the money! using the resource tracking heat map to increase the transparency, accountability and efficiency of health spending

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ABSTRACT

It is estimated that 23 cents of every dollar spent on health is directed towards vertical programs in HIV/AIDS; in some countries as little as 6 cents is directed towards family planning. However, what portion of that 23 cents or 6 cents actually reaches the point-of-service? The Resource Tracking Heat Map is an innovative approach that allows countries to visually follow the flow of funding through the health system. Through a color-coded display, the heat map provides a visual summary of where resources are getting stuck in a health system, resulting in decreased funds at the point-of-service. It identifies points of diversion (loss of funds), potential reasons for these diversions and the amount of allocated funds that eventually reach the point-of-service. The concept draws from energy transmission and medicine. Different colors on the heat map represent different types of constraints and illustrate relative severity. For example, significant losses in transmission show up as 'red'; low transmission loss shows up as 'green.' Following the dollar as it makes its way through the system is analogous to injecting a medical dye and using its movements to diagnose underlying problems. An increased understanding of resource flows will help countries minimize the level of loss across the system. Countries will be able to recognize weaknesses in the system and prioritize actions to increase the efficient use of allocated program funds. While specific country objectives will vary, the Resource Tracking Heat Map methodology allows countries to: (1) Assess the flow of funds as they go through the system to the point of service; (2) Identify and evaluate resource diversions at different levels; (3) Increase understanding of resource flows to inform decision-making and resource allocation; and (4) Identify and prioritize opportunities to improve more efficient use of health funds.
The application of drug sales surveillance system in rural areas

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ABSTRACT

Background: Public health researchers are increasingly interested in the use of monitoring data on pharmaceutical sales, which might provide a convenient, meaningful and timely indicator of public health conditions. We explored the application of drug sales surveillance system in rural areas, aiming to improve the early warning capacity of infectious diseases in rural areas. Methods: A web-based drug sales surveillance system, which covered 23 pharmacies (including 11 county pharmacies and 12 township pharmacies) in two rural counties of Hubei Province in China, has been established and started running since April 1, 2012. A total of 98 drugs with five drug categories including compound cold medicine, antibiotics, antidiarrheals, cough suppressants, antipyretics were monitored. Data from January 1 to December 31, 2013 were extracted for analysis. The time trend of sales volume for total and different drug categories were described respectively. Results: 415,956.7 packing units were reported, with 49.5 packing units reported per pharmacy per day on average. Compound cold medicines, cough suppressants and antibiotics were the main categories reported in the system, compound cold medicines accounted more than 40% of total drug sales volume. The drug sales volume showed obvious seasonal fluctuations, which appeared to be rising in January, April, October and December. The time trend of sales volume for township pharmacies was similar to that for county pharmacies though the fluctuations for township pharmacies were more gently. The time trend of daily sales for different drug categories also fluctuated seasonally. Conclusions: The study successfully constructed and implemented a drug sales surveillance system in the rural areas of Hubei Province. It was indicated that there were seasonal fluctuations on the trend of daily drug sales volume. However, more efforts are needed to explore the possibility of using drug sales in the early detection of infectious diseases in rural China.
Inducement price to enhance community-based methadone service effectiveness in China: A cluster randomized controlled trial

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ABSTRACT

Background Community-based methadone maintenance treatment (MMT) in China faces problems of poor retention and high rates of continued drug use. We evaluated the persistence and effectiveness of an adapted inducement price intervention on improving community-based MMT service effectiveness. Methods A two-group cluster randomized controlled trial was conducted in Guangdong province, China, between May 15, 2011 and May 19, 2013. MMT clinics were randomized in a 1:1 ratio to inducement price intervention and usual treatment (control). The protocol lasted 48 weeks, including a 24-week intervention following by a 24-week monitoring. Clients in the intervention group had the opportunity to draw for prizes contingent on attending treatment daily and testing negative for drug. The primary and secondary outcomes were retention and negative urine testing rate at 24 and 48 weeks. Results Eight clinics with 391 clients were randomized and analyzed (four clinics with 160 clients to intervention, four clinics with 231 clients to control). At 24 weeks, the intervention group had significantly higher retention (75.4% vs. 54.2%) and negative urine testing rate (87.1% VS. 66.4%) than the control group. The effectiveness of the intervention persisted longitudinally. At 48 weeks, retention (56.7% vs. 41.7%) and negative urine testing rate (91.7% vs. 62.9%) for the intervention group were still significant higher than the control group. After controlling for client- and clinic-level factors, clients received the intervention were 1.5 (95%CI: 1.1–2.0) times more likely to maintain in MMT and 2.3 (95% CI: 1.8–3.1) times more likely to reduce concurrent drug use. Discussion/conclusion Inducement price, during or after the intervention, was effective at helping clients to maintain in community-based MMT and reduce drug use. By improving retention, the intervention would provide better opportunities for drug users to use health services are (or will be) integrated in community-based MMT and improve their health.
Surveillance for adverse events following immunization in Futian district of Shenzhen, China

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ABSTRACT

Background Immunization is an essential component of public health policies to control infectious diseases. Comprehensive surveillance of adverse events following immunization (AEFI) is required to detect potential serious adverse events that may not be identified in pre-licensure vaccine trials. Against this situation we analyzed the characteristics of the AEFIs and evaluated the implementation of AEFI surveillance system, which is crucial to provide advices about improving surveillance systems as well as to strengthen the surveillance and evaluation of vaccine safety and effectiveness. Method Descriptive epidemiological analysis was conducted on the surveillance data of AEFI in Futian district of Shenzhen, China from 2009 to 2013. Result 1557 cases of AEFI were reported in total with an incidence rate of 39.64 per 100,000 population, the integrity rate and timely report rate reached almost 99%. Measles-rubella vaccine showed highest incidence rate of AEFI (202.92 per 100,000 population), then followed by 7-valent pneumococcal conjugate vaccine (187.04 per 100,000 population). 74.50% cases of overall occurred at ages less than two years. 54.34% cases were occurred in period from May to September, and 76.50% of overall episodes occurring in 24 hours after vaccination. 73.47% AEFIs presented injection site reactions, 16.69% presented abnormal reactions, and coincidental illness, 7.77%. The major clinical symptoms were local reactions with reddening, pain, and induration, 73.22%, and allergic eruption, 13.81%. Of all AEFIs, 99.87%... turned to be better and got cured. Conclusion The AEFI surveillance system of Futian district indicated that vaccines have proven to be generally safe in Futian district and successfully showed that the system which allowed for active, real-time monitoring of vaccine AEFIs based on self-report could be implemented, and the sensitivity of AEFI monitor was gradually improved with extending of the AEFI surveillance system application.
Survey on the experience of the patients and medical workers towards family doctor system in Shanghai

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ABSTRACT

The pilot program of the family doctor system has been implemented in Shanghai for nearly three years, which is the key to establish the coordinated and people-centered healthcare system, so we wondered exactly how it impacts people. A questionnaire was adopted from September to November of 2013 among 497 patients (including contracted and non-contracted) and 40 medical workers of two pilot community health care centers (CHCs), with emphasis on their experience towards the family doctor system. In-depth interviews with the head were also conducted. We found 66.7% of the contracted patients, who used not to visit CHC for first contact before signing up with the family doctor, visit CHC for first contact when getting a mild illness after signing up. Moreover, many contracted patients feel obvious improvement after signing up, such as more convenience of seeing the doctors, better health management provided by the doctors, and better attitudes of the doctors. However, there is no significant difference in the average medical expense per outpatient between the contracted patients and non-contracted patients. In addition, the medical workers are not so enthusiastic to the work due to the increase of their workload after the pilot and the current unreasonable performance evaluation system. We concluded that Family doctor system, as a new kind of healthcare delivery system focus on residents, could effectively improve experience of visiting CHC, change behavior of first contact, and further increase utilization efficiency of the medical resources. Nevertheless, there inevitably existed some problems during the development of this system, especially lack of preferential policy in medical expenses of the contracted patients and incentive mechanism of medical workers. Therefore, we suggested that the reimbursement of the contracted patients should be raised, and the performance appraisal system of the medical workers be reformed with 'flexible indicators' into consideration.
Is community case management sustainable in Mozambique?  
A qualitative policy analysis

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ABSTRACT

Background In Mozambique, community case management (CCM) of diarrhoea, malaria and pneumonia is embedded in the national community health worker (CHW) programme. Since 1978 this programme functioned fitfully and was relaunched in 2010, with a target to train and retrain over 6000 CHWs. Considering the checkered history of the CHW program, sustainability lies at the heart of concerns related to the design and implementation of CCM in CHW programs at scale in Mozambique and in people centred health systems more broadly. Methods Using qualitative retrospective case study methodology, we reviewed 54 national documents and interviewed 21 key national informants for a policy analysis of CCM in Mozambique. The data was analysed thematically according to a sustainability framework and validated though a national debriefing workshop. Results The sustainability of CCM was facilitated by embedding it in the national CHW programme, which was relaunched after wide consultation within government and with supportive donors and non-governmental organizations (NGOs). Although communities were not widely consulted, they were eager for CHWs to provide curative services. The new CHW program aimed to improve CHW retention, by paying them a salary and giving priority to females. However, salary costs come from partners and in practice most CHWs are male. The poor capacity of the health system to adequately supervise CHWs and guarantee drug supplies for CCM, the dependence on external partners for funding, and on NGOs for implementation and the lack of mobilization of communities and top policy makers remain critical concerns. Conclusions Embedding CCM in the national CHW programme favoured sustainability, however this made CCM susceptible to the same factors that undermine sustainability of the CHW programme. Moving forward, these policy concerns need to be addressed to ensure a national CHW program, responsive to community needs, supportive of CHW themselves and owned by national governments.
Early outcomes of diffusion of AIM Health innovations in Uganda: Multi stakeholder perspectives

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ABSTRACT

BACKGROUND: Uganda is among the countries that have made insufficient progress in Millennium Development Goals 4 & 5. The health worker to population ratio is a strong determinant of infant, under-five and maternal mortality rates. One approach to the scarcity of health workers has been the use of community health workers to encourage positive health seeking behaviours. AIM-Health [Access to Infant and Maternal Health] is a World Vision-Ministry of Health programme delivered at the household by community health workers (CHW), using the Timed and Targeted Counselling (tTC) approach to improving maternal and child health. This study analysed, adoption and early outcomes of implementation of the CHW led tTC program from a diffusion of innovation framework, and influence of referral pathways. METHODS: Fifteen focus group discussion and 45 key informant interviews with key stakeholders, program beneficiaries and non-beneficiaries were conducted in Kabaale and Busia Districts. Qualitative content analysis was used to analyse the data. RESULTS: Positive emerging results included time sensitive antenatal attendance, improved health seeking behaviours for delivery and to limited extent PNC services. The one-on-one discussion between CHWs and women influenced women to move away from traditional harmful behaviours and beliefs. Beneficiaries considered tTC to be a catalyst for male involvement in MCH services, emerging referral pathways and community linkages. One critical concern articulated was that the demand for services created by the programme was not matched with quality service delivery at health facilities. CONCLUSIONS: Progressive dissemination and adoption of the program at community, district level has a multiplier effect and reinforces the community health systems. There are positive prospects for sustainability and institutionalizing of the program. The tTC platform holds sizeable potential for improving health seeking behaviours, uptake and demand for MCH services. Addressing the access-quality gap will improve program effectiveness. Key words: Maternal Child health, AIM Health, Diffusion, Uganda
The effect of relative geographic remoteness on maternal and child health care in a rural Liberian population

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ABSTRACT

Background: Demographic and health surveys in resource-limited settings typically classify populations broadly as rural or urban when assessing the effect of geographic barriers to care. Relative remoteness within rural areas is rarely assessed, partially because highly remote areas are the hardest to survey. We hypothesized that distance from health facilities would correlate with worse health indicators among a remote population in southeastern Liberia. Methods: We conducted a cluster-sample survey of 600 households in Konobo District, Liberia, to guide development of a community health worker (CHW)-based healthcare system. We used standard international measures for common conditions and health utilization. We fit multiple logistic regression models, adjusting standard errors for cluster sampling, to estimate relationships between GPS-measured distance to facility and key indicators of health utilization. Results: Respondents lived a median of 28.9 km (IQR 14.8-34.6) from the nearest health center. Adjusting for predicted confounders (maternal age and education, marital status, and refugee status, and child’s gender and age), living in the farthest quartile versus the closest was associated with lower odds of children receiving deworming treatment (AOR=0.120, p=0.001). While the likelihood of seeking care for childhood ARI or diarrhea was not significantly associated with distance, households in the farthest quartile were significantly less likely to seek care from a formal healthcare provider (instead of a traditional or informal provider) for ARI (AOR=0.03, p=0.005) and diarrhea (AOR=0.05, p=0.03). Women living in the farthest quartile were significantly less likely to seek care from a formal healthcare provider (instead of a traditional or informal provider) for ARI (AOR=0.04, p=0.001), four or more times (AOR=0.12, p<0.001), or deliver in a facility (AOR=0.39, p=0.008). Conclusions: Within this population, relative remoteness is strongly associated with worse access to services. Granular measures of geographic barriers to care in such settings will improve services. Programs providing healthcare in similar contexts should decentralize interventions to mitigate geographic barriers, including through CHW programs.
What makes community health workers effective in different contexts? A participatory realist review.

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ABSTRACT

Background An increasingly common approach to strengthening community-based health systems involves the use of peer support, provided by community health workers (CHWs). Although CHWs are effective in promoting health, a recent Cochrane review (Glenton et al, 2013) noted that published studies do not contain data on the interaction between sociopolitical contexts and health systems delivery. As a result, little is known about the ways in which various contexts interact with mechanisms to either increase or dilute the effectiveness of programmes. Methods We conducted a participatory realist synthesis to develop a better understanding of the potential for community-based peer support (CBPS) to promote better health literacy. Active involvement by 120 paid/unpaid workers enabled us to compare findings from published studies with practitioner experiences. The patterns identified were used to explain how systems promote/hinder programme delivery and how CHWs are enabled or constrained in providing support. Results: Organisations adopting an authoritarian stance maintained control but limited the ability of workers to exercise autonomy and use experiential knowledge to deliver appropriate support. Organisations that negotiated co-design of programmes enabled CHWs to establish relationships with vulnerable groups. Organisations need to prioritise the assessment of community challenges and needs, investigating root causes of poor health and wellbeing. Adequate time should be devoted to developing relationships and connections before evaluation. Experiential cultural knowledge needs to be used at all stages of design and implementation, requiring the sponsor organisations to be willing to balance the sharing of control with governance. Discussion/Conclusions: The potential of CHWs offering peer support is dependent upon the surrounding equity context. Health systems need to assess the gaps in equity context before implementing PS programmes; establish adequate and protected time for the development of trust and relationships across providers and community groups; empower CHWs to draw upon their experiential knowledge.
Team based approaches with multi-level stakeholders improve the use of resupply procedures and enhance product availability with CHWs

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ABSTRACT

Background: In Rwanda, 30,000 volunteer community health workers (CHWs) treat children under five for pneumonia, diarrhea and malaria. A 2010 baseline assessment of the community supply chain identified a lack of CHW logistics data visibility and poor coordination between CHWs, health centers (HCs) and districts as barriers to product availability at the community level. SC4CCM tested a combined approach to improving product availability: standard resupply procedures (RSPs) enhanced by establishment of multi-level quality improvement teams (QITs) to strengthen coordination and problem solving between districts, HCs and CHWs. QITs regularly met and used data to prioritize supply chain problems to address and developed action plans to improve use of RSPs and ultimately CHW product availability. The project trained all CHWs, HC and district staff and established 44 QITs across 3 districts. Methods: In 2013, the project conducted a mixed-methods midline evaluation of interventions in 10 districts. A quantitative survey measured key supply chain process, output, and outcome indicators. A difference-in-difference model was used and significance testing performed. Qualitative data was gathered through focus group discussions with CHWs and HC staff. Results: The team-based approach resulted in improved key outcomes. CHWs in quality collaborative districts had significantly greater availability of the five community health products on the day of visit, 25% greater than the comparison group. QITs were characterized by high participation in team meetings (75% attendance); collaborative problem solving and formal action plans, with 100% HCs documenting progress in monthly journals. Qualitative results confirmed the importance of multi-level teams and a structured approach in achieving results. Conclusion: Quality Improvement Teams can be effective with CHWs, but tools and practices need to be tailored to community level context and needs. Furthermore, the use of data and a structured method to problem solving and joint goal setting were important elements of the team approach.
Moving traditional to Community Skilled Birth Attendants (CSBAs) and barriers to strengthen community-based birthing services.

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ABSTRACT

Background: Generally, in Bangladesh home delivery with traditional birth attendant has been practiced in rural areas. To generate a pool of trained birth attendance, Government of Bangladesh launched a Community Skilled Birth Attendant (CSBA) program in 2004 nationwide where existing community health workers were trained on safer birthing techniques and given responsibilities to carry out deliveries at home and refer women with maternal complications to emergency care facilities. The study was carried out to apprehend the role of these health workers with their new responsibility. Methods: As part of a nationwide survey (Bangladesh Maternal Mortality Survey, 2010), a qualitative assessment was carried out in selected districts which included semi-structured interviews (20) with such health workers. Results: No significant differences were noticed in terms of performed number of deliveries between health workers with short experiences who usually stay outside of their service areas compare to health workers having longer experiences living in their service areas. Community people usually prefer TBAs for assisting birth at home who are known and perceived experienced rather than from this newly trained workers. However, when the TBA is unable to perform delivery, either they or families seek assistance from them. Health workers claimed lack of supervision and accountability for their newly appointed role, rather, were often criticized by their managers for performing this responsibility along with their existing duties. Other factors such as night time, long distance of patient's house and family context often deters them from performing this activity. Conclusions: Study findings indicate that policy makers, program manager should rethink the CSBAs program as alternative approaches to strengthen community based services. Since the program is associated with maternal health, proper monitoring and supervision for the these health workers or a totally different set of cadre, might useful to attain the positive impact.
Developing clinical leadership as a strategy for hospital transformation at district level

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ABSTRACT

Background: Poorly performing district hospitals compromise the achievement of universal health coverage, especially in rural settings. The international literature emphasizes that, in highly complex professional bureaucracies such as hospitals, decision-making directly affecting the quality of care (and even efficiency) largely occurs at lower levels of the management hierarchy and is the responsibility of clinical rather than managerial staff. This paper explores the potential of strengthening clinical leaders' capacity, and facilitating their participation in hospital decision-making processes, as a local strategy to unleash the potential of existing staff and management systems, and galvanise improvements in hospital quality and responsiveness.

Methods: This paper is based on an exploratory South African study which used a qualitative approach. The study involved a literature review, fourteen semi-structured interviews with purposively sampled international and local experts on hospital management and clinical governance, and feedback on a draft report by the initial - and five additional - key informants. Interview transcripts and e-mailed feedback were coded and subjected to thematic content analysis.

Findings: Effective clinical staff not only manage the care of individual patients but train other staff, develop services at primary and hospital level, and contribute to wider decision-making around health care priorities, resource allocation and clinical governance. Key clinical leadership positions are nurses in charge of wards and doctors acting as medical managers. Remaining in touch with clinical realities is fundamental to effective clinical leadership. Well-functioning clinical teams are able to overcome professional and line management silos through good communication. Dysfunctional administrative systems within the hospital and higher levels of the public health system threaten the retention of staff and compromise effective clinical leadership.

Recommendations: Clinical staff from all disciplines need leadership training. As part of developing support systems for clinical leaders, a new relationship needs to be forged between clinical and managerial staff.
Application of systems thinking: 12 months post intervention evaluation of a complex health system intervention in Zambia: The case of the BHOMA

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ABSTRACT

Introduction: Strong health systems are said to be paramount to achieving effective and equitable health care. WHO has been advocating for using system-wide approaches such as systems thinking to guide intervention design and evaluation. In this paper we report the system-wide effects of a complex health system intervention in Zambia known as Better Health Outcome through Mentorship and Assessment (BHOMA) that aimed to improve service quality. The analysis was guided by a novel evaluation framework based on building blocks for health system strengthening. Methods: We conducted a qualitative study in three target districts. In-depth interviews and focus group discussions were used to collect data from key informants and the community. We used a systems thinking conceptual framework to guide the analysis focusing on intended and unintended consequences of the intervention. Nvivo version 10 was used for data analysis Results: The community responded positively to the intervention leading to more demand for health services. The indications were that in the short term there was increased demand for services but the health workers capacity was not severely affected. This means that the prediction that service demand would increase with implementation of BHOMA was correct and the workload also increased but the help of clinics supporters meant that some of the work of clinicians was transferred to lay workers. However, from a systems perspective, unintended consequences also occurred during the implementation of the BHOMA. Several contextual factors seemed to interaction with the project positively or negatively. Conclusion We applied an innovative approach to evaluate a complex intervention in low income settings, exploring empirically how the systems thinking can be applied in the context of health system strengthening. Though the intervention had some positive outcomes by employing system-wide approaches we also noted unintended consequences
The importance of participatory decision-making in people centred health systems, for achieving health systems strengthening

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ABSTRACT

Background: It is widely agreed that Global Health Initiatives (GHIs) should contribute to Health Systems Strengthening (HSS) in the countries in which they operate, but examples of this being achieved are few. This study was undertaken to examine a GHI program's contributions to the health system beyond its own vertical objectives. Zanzibar is a small, contained society with a locally administered health system and relatively well-organised mechanisms for the collection of health data. Zanzibar has also made substantial progress in controlling malaria through a GHI programme. Methods: A range of health indicators recommended by the WHO for the assessment of health systems were examined for the period from 2000 to 2010 to identify trends indicative of HSS. In addition, interviews were conducted with Ministry of Health officials, primary healthcare providers and representatives of organisations involved in malaria control to evaluate GHI interaction with health system elements not directly involved in malaria control. Results: Indicator analysis confirmed substantial improvement in malaria and related diseases over the period but did not find evidence of improvements elsewhere in the health system. Meanwhile, analysis of qualitative data showed all interviewees recognised the need for GHIs to contribute to HSS but there was little consensus on how it should be accomplished or measured. The interviews also revealed a lack of communication between all stakeholders, notwithstanding the existence of forums specifically for this purpose. Conclusions: Poor communication between stakeholders will have contributed to the lack of consensus on how GHI projects could contribute to HSS and will have been a factor influencing the achievement of this objective. These findings demonstrate the importance of participatory decision-making in people centred systems and the need for governments to be more active in facilitating communication between stakeholders, helping to identify opportunities for coordinating development actions and encouraging stakeholder interaction.
Systems dynamics analysis of health systems resilience: Case studies from Cote d'Ivoire and Nigeria

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ABSTRACT

Background There is increasing interest in applying the concept of resilience to understand ways of promoting robust health service delivery in contexts of acute or chronic crisis. Identifying key sources of vulnerability and health systems structures and designs that promote resilient functioning can inform policy-making across a broad range of settings. Methods We have applied a systems dynamics approach of group model building in a series of case studies in settings where instability has provided major challenges to the operation of the health system. We report on two case studies: one focused on the continuation of HIV services during the political crisis that followed the disputed Presidential election in Cote d'Ivoire in 2010; the other on provision of MNCH services interventions in northern Nigeria in the context of the insurgency by Boko Haram. We describe the key stages of: defining a focal problem; interviewing key stakeholders; convening a participatory group modelling session where key factors are elicited and linkages between them identified; refining the resulting systems model using available data sources; and disseminating the model to support current and future health systems planning and preparedness. Results The systems maps generated indicate potential points of leverage for stakeholders to maximize health systems resilience in contexts of adversity. While analyses reveal unique features of each context, there are indications of recurrent systems patterns that promote resilience. These include the availability of collateral systems pathways; the narrowing of programmatic focus; and the alignment of stakeholder commitment. Discussion Group model building using a systems dynamics approach promises to be an effective methodology for convening stakeholders to develop a common view of sources of health systems vulnerability and potential points of leverage to strengthen resilience. It represents a powerful technology able to capture key aspects of the person dynamics crucial to health systems functioning.
WawaRed-PERU: 'Reducing health inequities and improving maternal care by improving health information systems'

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ABSTRACT

Background: In developing countries, information systems frequently lack adequate processes and quality data to support decision-making. This situation results in inequitable access to public health services that may not even respond to women’s needs, especially in low-income and rural populations. The goal is to improve health processes and outcomes through higher quality, timely data accessible to stakeholders at policy decisions making, and service provision levels and in turn to contribute to improve health equity among women.

Methods: We propose to develop a model of integration-interaction of maternal health information systems in Peru by applying interoperability principles and engaging with key stakeholders. Since August 2013, we have conducted a qualitative study (in deep interview and focus groups with stakeholders) to determinate the situation of maternal health information system and their usage decision makers and health providers. We have also conducted a baseline study to evaluate, before and after implementation, the sources, types and quality of data used by decision-makers from different levels of the Ministry of Health at the end of the project.

Results: Qualitative data shows that there are eight different maternal health information systems in Peru. Each one reports different information and none of them communicates or shares it with each other. In the majority of cases the decision-makers do not know which information system is accurate and can be used for making policies. Furthermore, health providers do not have access to the information they collect. Moreover, stakeholders highlight the necessity of training in data analysis.

Conclusion: Information health systems in Peru are multiple and are unable to interact without the implementation of standards of interoperability that will allow sharing information, improving the quality of information, and expanding the access to information.
Which intervention design factors influence performance of community health workers in low and middle income countries? A systematic review

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ABSTRACT

Background Community Health Workers (CHWs) are increasingly recognized as an integral component of the health workforce needed to achieve public health goals in low and middle income countries (LMIC). Many factors influence CHW performance. A systematic review was conducted to identify intervention design related factors influencing performance of CHWs. Methods We systematically searched six databases for quantitative and qualitative studies that included CHWs working in promotional, preventive or curative primary health services in LMIC. 140 studies met the inclusion criteria, were quality assessed and double read to extract data relevant to the design of CHW programs. A preliminary framework containing factors influencing CHW performance and characteristics of CHW performance (such as motivation and competencies) guided the literature search and review. Results A mix of financial and non-financial incentives, predictable for the CHWs, was found to be an effective strategy to enhance performance, especially of those CHWs with multiple tasks. Performance-based financial incentives sometimes resulted in neglect of unpaid tasks. Intervention designs which involved frequent supervision and continuous training led to better CHW performance in certain settings. Supervision and training were often mentioned as facilitating factors but few studies tested which approach worked best or how these were best implemented. Embedment of CHWs in community and health systems was found to diminish workload and increase CHW credibility. Clearly defined CHW roles and introduction of clear processes for communication among different levels of the health system could strengthen CHW performance. Discussion and conclusion When designing community-based health programs, factors that increased CHW performance in comparable settings should be taken into account. Additional intervention research to develop a better evidence base for the most effective training and supervision mechanisms and qualitative research to inform policymakers in development of CHW interventions are needed.
Interprofessional education in primary care health:
An opportunity for global action

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ABSTRACT

BACKGROUND Within the values that sustain primary health care centers worldwide (PHC) there is multidisciplinary work as the core to give an adequate answer to health problems. One well-recognized factor that reduces this ability is the scarce interaction between different disciplines during higher education training. Therefore, it is urgent to generate strategies that promote the global development of a health system based on PHC from university settings. One documented tool successfully used in the health professionals training is the 'Interprofessional Education' approach (IE). This study shows the experience of applying IE approach at Universidad del Desarrollo, Chile. We included students of medicine, nursing and physiotherapy. METHODS A case study was conducted. An IE-based guideline was provided during their last PHC training. This guideline was given to 2 groups of 3 multidisciplinary students. From the selection of a case, each group applied the IE-based guideline and designed an interprofessional strategy for action. Every student, through open-ended questions, was able to elaborate the main points of his/her experience and IE-based learning. Answers were labelled using thematic analysis. RESULTS Each group performed 3 sets of interprofessional consultations to 2 selected cases from the PHC center, applying a previously designed proposal for action. After the intervention, all students agreed on the high significance of this experience, which allowed them to 'learn about the contribution from other disciplines'. All of them suggested this experience should be a formal part of their undergraduate training. DISCUSSION/CONCLUSIONS IE approach could be an appropriate strategy to contribute to the training of health professionals. This would contribute to the development of the core underpinning values of PHC. The IE approach should be disseminated and further researched. This could be developed to enhance and catalyze interprofessional collaboration, not only at a local setting but also at a large global scale.
Participatory community based health planning: A strategy for sustainable improvement of community health in Zambia

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1Zambia Integrated Systems Strengthening Program

ABSTRACT

Background The Zambia National Health Policy envisions 'a healthy and productive citizenry'. Although the country had made progress toward reducing mortality rates (e.g. in malaria, pregnancy, AIDS and children under five years), the government sought to further decentralize and integrate services to address deeper social, environmental and cultural causes of health inequities. The Ministry of Health aimed to stimulate proactive community involvement to generate people-centered responses to their identified health concerns, complementing system-wide health initiatives. Methods: The Ministry of Health revised the 2005 Simplified Guide to Community Planning, targeting districts, health facilities and communities. Revision incorporated a robust people-centered approach, with content tailored to individuals with low literacy and emphasis placed on the important contribution of individuals to improved community health status. In 2012, Zambia Integrated Systems Strengthening Program (ZISSP) conducted community-based trainings for 860 Neighborhood Health Committee (NHC) members, representing 150 NHCs attached to 21 health facilities in seven districts. ZISSP monitored the inclusion and use of community action plans at district, health center and community levels. Results Trained NHCs facilitated the planning process in 140 communities, using peer-group brainstorming to identify and prioritize health challenges and generate possible interventions and solutions. Participatory community health planning involved men, women and youth, enabling gender- and age-specific contributions. Identified health challenges included malaria, diarrhea, HIV and home deliveries. Communities endorsed action plans prior to submission to health centers for inclusion into district plans and budgets. Discussion/Conclusions Involving communities in bottom-up planning contributes to sustainable improvement in community health outcomes. Active involvement of traditional leaders can support compliance to agreed health behaviors. Participatory planning enables community members to overcome poverty and literacy barriers to express their perceptions of health issues that personally affect them and to use local resources to improve their health.
An assessment of health extension workers linkages with community and health system: opportunities for strengthening community-based health systems in Ethiopia

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ABSTRACT

Background Health Extension Workers (HEWs) in Ethiopia have a unique position, as they connect the community to the health system. Qualitative research was conducted in southern Ethiopia to understand linkages between HEWs, the community and health system, in order to inform policy on optimizing HEW performance, specifically in maternal health. Methods We conducted six Focus Groups Discussions (FGDs) and 12 semi-structured interviews with HEWs and 14 interviews with key informants working in administration, curative services and supervision of HEWs. At the community level, we conducted eight FGDs with women or men, 12 interviews with women and six with traditional birth attendants. Interviews were recorded, transcribed, translated, coded and thematically analysed. Results HEWs had two-directional linkages with the community and health system. The most important linkages were related to referral, supervision, monitoring and support. The Health Development Army (HDA), a community-based structure supporting HEWs, identified pregnant women. HEWs referred high-risk cases to a health facility, with generally appropriate responses, although procedures were not standardized and there was no referral tracking mechanism. Supervisory structures of HEWs recently changed, leading to lack of clarity regarding roles in some settings. Supervision was found to focus on record checking and little on problem solving and learning. Involvement of the HDA in HEWs activities was not established everywhere. Health professionals, administrators, HEWs and community members occasionally met in special meetings to monitor HEW performance and program needs. Discussion and Conclusion HEWs intermediary position between the community and health system improves access to health services, but could be challenging for HEWs with regard to responsibilities and accountability towards both levels. Clearly defined roles and responsibilities at all levels and standardized support and communication mechanisms could facilitate HEWs in maximizing the value of their unique position, in order to improve their performance.
NeoKIP - Increased neonatal survival through facilitation of local stake-holder groups in Vietnam

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ABSTRACT

Different approaches to reduce neonatal mortality using awareness raising through women's groups have been proven to be effective. In the NeoKIP trial in Quang Ninh province, Vietnam, this concept was modified and fitted to the existing health system, thus better fitted for scale-up. Through facilitation of groups composed of local health care staff and politicians there was a reduction of neonatal mortality and improvements of maternal, delivery, and newborn care indicators. In a cluster-randomized design 44 communes were allocated to intervention and 46 to control. Laywomen facilitated monthly meetings during 3 years in groups composed of health care staff and key persons in the communes. A problem-solving approach was employed. Births and neonatal deaths were monitored, and interviews were performed in households of neonatal deaths and of randomly selected surviving infants. A latent period before effect is expected in this type of intervention, but this timeframe was not pre-specified. Neonatal mortality rate (NMR) from July 2008 to June 2011 was 16.5/1,000 (195 deaths per 11,818 live births) in the intervention communes and 18.4/1,000 (194 per 10,559 live births) in control communes (AdjOR 0.96 [95% CI 0.73-1.25]). There was a significant downward time trend of NMR in intervention communes (p=0.03) but not in control communes (p=0.184). No significant difference in NMR was observed during the first two years (July 2008 to June 2010) while the third year (July 2010 to June 2011) had significantly lower NMR in intervention arm: AdjOR 0.51 (95% CI 0.30-0.89). Women in intervention communes more frequently attended antenatal care (AdjOR 2.27 [95% CI 1.07-4.8]). The proposed oral presentation will cover the full story of NeoKIP, from planning and baseline to completion. Above results have been published in PLoS Medicine. Process evaluations and equity analyses have been performed and will be included in the session.
Emergency referral, community care, or strengthened facilities for improved maternal and newborn care in remote Myanmar: access and equity revealed through localised social mapping.

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ABSTRACT

Background In Myanmar, the United Nations Joint Initiative for Maternal, Neonatal and Child Health worked with government and non-government partners to increase access to essential services for hard-to-reach populations in areas most affected by the 2008 Cyclone Nargis. Burnet Institute helped evaluate their support to maternal and newborn health over 2010 to 2012. Methods A rapid survey in a purposeful sample of 15 villages (characterized by varying remoteness) of all mothers with living children born in the previous three years (459 mothers), supplemented by a localised social mapping tool previously validated in Myanmar, assessed trends and preferences in utilisation of care. Results and Discussion There is a general trend of increasing access to skilled birth attendance (but still at a modest level), emergency obstetric referral, and some aspects of immunization and antenatal care, indicating some (but not all) investments bore fruit. Only some gains reached poor and vulnerable populations: preventive care and unexpectedly high uptake of emergency referral. A gradient of disadvantage persists, relating both to physical access barriers, and to the interplay of social status and family preference. Social mapping could define the impact of socio-economic status (as locally defined) on differing access to various forms of care; highlighting specific gaps, some of which were surprising. Methods for determining who were deemed 'hard-to-reach' had a significant influence on equity outcomes. Conclusions and Significance The localised social mapping tool proved feasible in a rapid evaluation and allowed nuanced analysis within villages that would look homogenous when assessed by international poverty norms. Two important lessons for planners seeking balance between facility- and community-based investments in remote and difficult settings are seen in the methods for boosting emergency referral, and in the clarification of social variations in preference for home-based care.
Different models of hospital-community health center collaboration: An examination of variations in quality and efficiency of care for patients with chronic diseases

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ABSTRACT

Background: In recent years, in order to provide patients with seamless and integrated health care services, some models of collaboration between public hospitals and community health centers (CHCs) have been piloted in some cities in China. This study examines the nature and effects of these collaboration models.

Methods: Three cases - one for each of three different collaboration models - in three Chinese cities were selected to examine variations in quality and efficiency of care for selected chronic diseases, using ‘structure’, ‘process’ and ‘outcomes’ indicators, descriptive statistics, Pearson χ2 inspection and ordinal logistic regression.

Results: The Direct Management (DM) Model in Wuhan exhibited better structure indicators than the other two models. In terms of patients’ satisfaction, there were no statistically significant differences in patients’ perceptions of communication between hospitals and CHCs regarding their illness. Patients from the DM Model had odds of being in the ‘satisfied’ category that were 28.9% less than those from the Loose Collaboration (LC) Model in Nanjing. Staff in the DM Model had the highest satisfaction level (77.6%) with respect to patient referral. Close to a quarter of the patients in the DM Model perceived their current health condition as better than in the previous year, which was the highest among the three models. Overall, the efficiency indicators were lower in the LC Model than in the other two models.

Conclusions: Communications between hospitals and CHCs and among care providers were generally inadequate. Many of doctors were not knowledgeable about the nature of collaboration and their enthusiasm was not high. Publicity about hospital-CHC collaboration is inadequate, resulting in low awareness among patients and even among health professionals. Further research to examine the nature and the strengths and weaknesses of different models could help guide the future development of hospital-CHC collaborations.
Scaling up innovations for community based planning, implementation and monitoring of maternal and neonatal health services during village health and nutrition days

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ABSTRACT

Background - Village Health and Nutrition Days (VHNDs), a global best practice, is being implemented in rural India as a priority intervention. The following 4 pre-tested innovations were scaled-up in 196 villages with 222,734 population; through 7 Government Primary Health Centres in rural Maharashtra, India: 1. Monthly micro-planning of MNH services by ASHAs (Community Health Workers) 2. Active linkage of clients with monthly VHNDs conducted by Auxiliary Nurse Midwives. 3. Monthly need specific, interpersonal communication and counseling by ASHAs. 4. Community based monitoring by Village Health and Nutrition Committees

Methodology: Data from the Monthly Surveillance and Monitoring System (MSMS) validated by external investigators were used for assessing the efficacy of the innovations. Time series research design was used to compare service coverage in 2010, 2011 and 2012. Findings: On an average 91.0% households were covered by ASHAs for monthly assessment of maternal health needs. In young women <19 years, early ANC registration increased significantly in 2012 compared to 2010 [OR 1.98, 95% CI (1.59-2.5)]. Coverage with iron folic tablets increased [OR 3.35, 95% CI (2.70-4.17)]. Coverage with minimum, standard antenatal care increased from 67.1% to 86.0% [OR 3.01, 95% CI (2.44-3.72)]. Contraceptive use increased from 13.0% to 18.5% (p=0.000). Proportion of LBW babies reduced significantly from 22.0% to 11.7% (p=0.000). During the same period, in women >20 years, early ANC registration increased significantly [OR 2.21, 95% CI (1.9-2.6)]. Coverage with iron folic tablets increased [OR 3.28, 95% CI (2.77-3.89)]. Coverage with minimum, standard antenatal care increased from 64% to 85.0% [OR 3.19, 95% CI (2.70-3.77)]. Contraceptive use increased from 36.0% to 41.0% (p=0.007). Conclusions and Recommendations: The innovations can be scaled up in India by ASHAs and auxiliary nurse midwives during village health and nutrition days, resulting in a measurable increase in coverage with maternal health services.
Role of medical institutions in health systems improvement: Experiences from North India

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ABSTRACT

Purpose: Indian health system follows federal structure with states and districts accountable to deliver the health services. National Rural Health Mission in India, is forcing the states, to improve performance. However, states lack capacities for the same. Medical colleges located in the state are not generally integrated with this general health system. Thus, the tremendous potential available in these medical colleges remains largely untapped. The mechanisms and extent to involve medical colleges are unclear. We share some experiences from North India for health systems improvement through coordination with health systems. Focus/contents: Following experiences from North India will be presented: 1. Capacity Building: Innovative training methodologies on planning implementation for district officials, integrated management of childhood illnesses, infant death reviews, maternal death reviews and stillbirth reviews, and to do supportive supervision will be shared. 2. Concurrent evaluation & Quality Measurements: We did concurrent evaluation and quality measurements in Himachal Pradesh, highlighted percent reporting of births and deaths, and identified gaps in conduct of family planning camps. We could help the districts in organizing Reproductive and Child Health Camps with quality. 3. Supportive Supervision: In Haryana, intensive supervisory activities are being undertaken by involving the faculty and staff of medical colleges. It is proving to be very useful in generating unbiased information for action. 4. Community Empowerment & Monitoring: In one district of Himachal Pradesh, we empowered women groups with information and involved them in monitoring of peripheral health institutions. These women groups were successful in creating pressures on health systems for improvement. We undertook an evaluation of implementation of community based monitoring under NRHM in Chandigarh and found that activity is being undertaken, with minimal involvement of community. Significance: Experiences show pathways to involve medical colleges in capacity building, planning, supervision, monitoring, community empowerment and community monitoring, and making the systems more responsive and accountable.
The role of Community Health Workers in eliminating neonatal mortality related community risk factors

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ABSTRACT

ABSTRACT: Background: Uganda still has a very high neonatal mortality rate, 26 deaths per 1,000 live births. Most of these newborn deaths occur at home, especially among the rural poor. Evidence shows that timely access to quality neonatal health services could significantly reduce neonatal deaths, however there is paucity of data on community factors associated with neonatal mortality in rural communities. Methods: A baseline survey conducted in July 2013 in three districts of Pallisa, Kibuku and Kamuli provided data for this analysis. A total of 2,238 women, aged 18-49 years, who had delivered in the last 12 months were interviewed. The NMR was determined as number of neonatal deaths within the last 12 months per 1000 live births. Risk factors for neonatal mortality were determined using Relative risk ratios, estimated using a Log-binomial regression model. Results: The overall NMR in the three districts was 42 per 1000 live births; Factors significantly associated with lower risk of neonatal death were CHW’s visit to the pregnant mother (RR=0.23, 95%CI=0.057-0.92, p=0.0144), mother’s knowledge of danger signs during pregnancy (RR=0.24, 95%CI=0.06-0.97, p=0.02), and pregnancy months at the first ANC (RR=0.24 CI=0.31-0.846, p=0.01). Mother’s knowledge of newborn danger signs (RR=0.64, CI=0.40-1.01, p=0.0723), and attending at least 4 ANC visits (RR=0.72, CI=0.48-1.09, p=0.1174) were associated with lower risk of NMR but these were not statistically significant. Conclusions: CHW’s visit to pregnant mothers was an important determinant of lower neonatal death. The effect of mother’s knowledge of danger signs for babies and themselves on lower risk of neonatal death may be as result of CHW’s home visit. CHWs are one of the new cadres who can play an active role in increasing maternal and newborn knowledge as well as encouraging women to access maternal services.
A geospatial analysis of access to the community health service in Jinan City, China

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ABSTRACT

Background: Access to health services is an essential concept in a healthcare system, especially for community-based primary care. Developing a Community Health Service (CHS) system (through establishing CHS centres) in order to provide primary care services for all urban populations was positioned as a key component in the Chinese government's national health reform plan launched in 2008. This study carries out a comprehensive analysis of access to the CHS in Jinan City, one of the first cities to launch CHS in China.

Methods: The study examines access to CHS from both the service providers’ perspective (potential accessibility) and the service users’ perspective (revealed accessibility). Based on GIS techniques, we map and analyze the spatial provisions of the CHS across Jinan City. By conducting 2,200 household questionnaire surveys, we explore local residents' actual need, awareness, utilization and perception of the CHS.

Results: We find that there is significant inequality in the spatial provision of CHS across Jinan. People living in inner urban areas and wealthy residential areas have better potential accessibility to CHS than those living in suburban areas and deprived residential areas. However, we also find that residents living in deprived areas have significantly higher need, awareness and utilization of CHS than those living in wealthy areas. Age, income level, health insurance type and distance to healthcare facilities are significant associated with people's awareness and utilization of CHS.

Conclusion: The findings present the inequality and inequity of CHS provision in Jinan. Related policy recommendations are brought forward from this research for local government, contributing strategies for improving the effectiveness of CHS system. This study is the first research which comprehensively investigates the issue of access to CHS in China. The research framework, findings and policy implications may provide lessons for other cities in China as well as other developing countries.
Learnings from multiple international case studies of people-oriented comprehensive primary health care: Lessons for research, policy, and implementation.

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ABSTRACT

Background. When implemented as envisioned, comprehensive primary health care (CPHC), with its focus on equity, accessibility, participation and holistic care, can foster person-oriented, community-based health services. This presentation will synthesise findings and discuss research challenges from the international Revitalizing Health for All project and the Australian CPHC in Local Communities project. Methods. The international project, using ‘triads’ of new researchers, research mentors and health managers, researched innovative CPHC initiatives in Africa, Asia, and Latin America, and Indigenous communities in Australia, New Zealand and Canada. In the Australian study, case study services included four state government managed services, one non-government organisation, and one Aboriginal community controlled service. We developed program logic models for each service and evaluated services against the logic models. Results. Scope for implementing CPHC at the Australian state managed services was constrained by an unsupportive policy environment. This stalled implementation and unsupportive environment is comparable to the Indian, South African, and Argentinian case studies. The Aboriginal community controlled service has been able to protect its comprehensive approach. The need for supportive policies and financing models permeates all the case studies. Collectively the case studies highlight (1) how to study CPHC whilst building research capacity, and (2) how to engage managers and policy makers during the process, particularly in rapidly changing political or ideological contexts and reconfigurations of health systems (e.g., Colombia, Ethiopia, India, South Africa, and South Australia). Discussion/Conclusions. Our findings contribute to the evidence base for CPHC by providing a program logic model for its operation and highlighting the conditions necessary for its implementation. We used innovative methods which involved local managers and implementers to capture the complexity and context-sensitive nature of CPHC. The studies indicate that CPHC is crucial to promoting a health system that is responsive, community-centred and founded on the ideals of human rights.
Community Action for Health (CAH) in India

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ABSTRACT

Objectives The objective of the abstract is to discuss the findings of an evaluation of Community Action for Health (CAH) implemented as a pilot in thirty six districts across nine states in India between 2007-2009. Background CAH is a key strategy under National Health Mission (NHM), which places people at the centre of the process of ensuring fulfillment of health needs and rights of the community. CAH has empowered rural communities to take charge of their health and engage with the government to ensure that the public health services reach them and their entitlements are met. CAH process involves formation and strengthening of Village Health, Nutrition and Sanitation Committees (VHSNC) at the village level; creating awareness on health entitlements; training VHSNC members to collect data and monitor health services; and conducting social audits to highlight gaps and find solutions. Methods The study used qualitative methods including focus group discussions with the community and VHSNC members and in-depth interviews service providers and programme managers. Results The CAH process has empowered the community, especially marginalized groups to engage with health department, strengthened service delivery and facilitated communities in availing health entitlements. The process brought accountability among the service providers in relation to service delivery and meeting community needs. Successful outcomes of the process depended on the following: engagement of civil society groups in training and facilitation; use of standardized tools and methods to undertake data collection; avenues/forums to share the data and mechanisms for timely redressal of grievances. Conclusions and Implications CAH ensures improved range, access and quality of services, and also enables planning and corrective action. The civil society engagement, resources and especially commitment from the health system is pre-requisites for supporting the scaling up the CAH process.
Community leaders as change agents for HIV activities in Kalomo District of Zambia

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ABSTRACT

BACKGROUND The Zambian government envisions active participation of rural communities in health interventions. To support this goal, the USAID-funded Zambia Integrated System Strengthening Program (ZISSP) targeted Kalomo, a district with higher HIV prevalence (15%) than national and provincial rates, aiming to engage communities to improve HIV-related service uptake. METHODS From January 2012 to December 2013, ZISSP implemented behavior change approaches in Mukwela (population: 3,262) of Kalomo District. Participatory Learning and Action methods enabled participation across gender, education and age groups and involved community leaders (traditional, civic, religious). Matrix ranking identified most common and serious health problems. The community-generated action plan included local and external resources and engaged local leaders and the Community AIDS Task Force. Behavior change approaches primarily targeted pregnant women and spouses, people living with HIV, and youths. Methods included group, individual discussion, door-to-door campaigns, local radio station broadcasts, drama, HIV educational material provision. Monthly and quarterly monitoring of service uptake (number of people accessing Prevention of Mother-to-Child Transmission, male circumcision, anti-retroviral therapy, and voluntary counseling and testing services) used Health Management Information System data and community reports. RESULTS Behavior change activities resulted in significant uptake of HIV-related services. Between 2012 and 2013, VCT uptake increased from 150 to 1,024; Male involvement in PMTCT increased from 15 to 373. ART referrals to the district hospital increased from 99 clients (67 F, 32 M) in 2012 to 203 clients 117 F, 86 M in 2013. Over 160 community leaders (102 new) participated in disease prevention and health promotion activities, addressing socio-cultural issues driving HIV incidence (polygamy, early marriage). DISCUSSIONS /CONCLUSIONS The strategy of promoting community-owned plans and including local leaders in Kalomo District successfully increased uptake and awareness of HIV services. Sustainability of HIV-related behavioral interventions requires additional community orientation with behavior change strategies and income generation projects. Experience of learning communities and knowledge translation platforms engaged in strengthening health systems.
Innovation in health service delivery: Integrating community health assistants into the health system at district level in Zambia

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ABSTRACT

To address the huge human resources for health (HRH) gap in Zambia, the Ministry of Health launched the National Community Health Assistant Strategy in 2010. The strategy aims to integrate community-based health workers into the health system (HS) by creating a new group of workers, called community health assistants (CHAs). Conceptually informed by Diffusion of Innovations (DOIs) theory, this paper qualitatively explores the integration of CHAs into the HS at district level in Zambia during the pilot phase. Data gathered through review of documents, focus group discussions and key informant interviews were analysed using thematic analysis. The perceived relative advantage of CHAs over existing community-based health workers in terms of their quality of training and scope of responsibilities, as well as the perceived compatibility of CHAs with existing groups of health workers and community healthcare expectations positively facilitated the integration process. However, limited integration of CHAs in the district health governance system hindered effective programme trialability, simplicity and observability at district level. Specific challenges at this level included a limited information flow and sense of programme ownership, and insufficient documentation of outcomes. The district also had difficulties in responding to emergent challenges such as delayed or non-payment of CHA incentives, and inadequate supervision and involvement of CHAs in the health posts where they are supposed to be working. Furthermore, failure of the HS to secure regular drug supplies affected health service delivery and acceptability of CHA services at community level. The study has demonstrated that implementation of policy guidelines for integrating community-based health workers in the HS may not automatically guarantee successful integration at the local or district level, at least at the start of the process. The study reiterates the need for fully integrating such innovations into the district health governance system if they are to be effective.
Community-based TB control in Myanmar: cost and contribution of TB patient self help groups

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ABSTRACT

Background: TB patient Self Help Groups (SHG) have been established and functioning in Myanmar to help TB patients and their families to complete treatment, be cured from TB and lead the community response towards TB. Community-based TB control is priority strategy for National TB Program in Myanmar. Therefore information on the cost of establishing SHGs and their contribution for community-based TB control are necessary to replicate this strategy. Objective: To access the costs of TB patient SHGs and to find out their contributions for TB control Methods: This cross-sectional study was conducted in one of the high TB burden townships, Hlaingtharyar during 2013. Cost data of four SHGs were obtained by reviewing records and interviewing with the tool to categorize cost. Document review, five focus group discussions and nine key informant interviews were performed to find out activities of SHGs for TB control. Results: The SHGs composed of old TB patients, family members of TB patients and volunteers. Costs spent for four SHGs ranged from US$ 1297 to 2848 per year. Average cost per SHG for TB control activities was approximately US$257.2 per year. TB control activities of SHGs were referring TB suspects to health centers, providing health education, performing Directly Observed Treatment (DOT) and supporting nutrition for TB patients. On average one SHG referred 72 TB suspects and provided DOT for 64 TB patients per year. Cost for one TB patient to get diagnosis was US$ 19 and one TB patient to complete treatment was US$ 23.5. TB control activates of SHGs contributed 46% of case detection in Hlaingtharyar. Conclusion: Although there was some additional cost to conventional DOT, the SHG approach was effective in TB control. Empowerment of the TB patients and improvement in case detection as well as treatment completion has been accomplished simultaneously through this approach.
Effects of a randomized intervention to improve workplace social capital in community health centers in China

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ABSTRACT

Background: How to attract and retain qualified human resources is a major challenge to develop an effective and efficient community health services in China. Workplace social capital (WSC) represents a significant predictor of organizational commitment of those working in the field of patient care. Some scholars argued that it is possible to increase worker commitment and decrease turnover by fostering WSC. This study aims to examine whether WSC will be improved after implementing a randomized WSC intervention in community health centers (CHCs) in China. Methods: This study was conducted in 20 similar-size CHCs in Jinan of China during 2012-2013. Using the stratified site randomization, 10 centers were distributed into the intervention group. A six-month WSC intervention was implemented, including team building courses for CHC directors, voluntarily public services, group psychological consultation and outdoor experiential training. The translated and culturally adapted WSC scale included two dimensions: linking and non-linking WSC. The WSC intervention effects were measured by 227 respondents who participated in both the baseline and follow-up surveys. We did a bivariate Difference-in-Difference analysis to analyze the individual-level and facility-level WSC intervention effects. Results: The intervention increased the individual-level WSC total score, linking WSC score and non-linking WSC score by 2.8, 1.5 and 1.2 points (all statistically significant at 0.01); and it increased the facility-level WSC total score, linking WSC score and non-linking WSC score by 2.8, 1.4 and 1.3 points (all statistically significant at 0.01). However, for the control group, no statistically significant changes on all three WSC indicators were found in both levels. Conclusions: The comprehensive WSC intervention package in this study, improved WSC among CHCs in urban China. In the future, further studies will be conducted to examine the impact of WSC improvement on job satisfaction, job performance and turnover.
Experiences in piloting a population level pregnancy and outcome tracking system in rural Eastern Uganda

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ABSTRACT

Background Understanding pregnancies and their outcomes is crucial to designing effective policies and interventions. We aimed to develop a low cost research platform for early detection of pregnancy, tracking of pregnancy outcomes and to integrate this with promotion of safe birth and newborn care in rural eastern Uganda. Methodology The MANEST Project is a community-facility linked intervention study. It is being implemented in Luuka district in Eastern Uganda. Trained community health workers (CHWs) register all pregnant women and make monthly visits to identify pregnant women and sensitize them on maternal and newborn care. An interview using a PDA is done and location taken using a GPS. All data is downloaded into a designed database and to a computerized Pregnancy-Tracker which automatically calculates expected dates of delivery (EDD) and also flags women who will deliver one month or two weeks' and also those expected to have delivered a month ago. This data is extracted from the system and fed to super CHWs to warn expecting mothers to ensure birth preparation and CHWs to do after delivery follow-ups to deliver community based PNC. Results A total of 36 CHWs and 6 super CHWs are involved. The Pregnancy-Tracking system has been able to calculate and determine EDDs for over 500 pregnant women and their respective socio and geo-locations. Out of 574 recruited women, 380 have given birth and postnatal visits and interviews are undergoing. Expected outcomes will include total pregnancy surveillance at population level for rates such as abortion, prematurity, institutional deliveries, perinatal and neonatal mortality rates. Conclusions Implementing a computerised pregnancy-tracking system is feasible and can be used to improve intervention delivery but also to accurately identify pregnancy outcomes. However, there is need to integrate into it innovative low cost methods for early determination of pregnancy status by using Community health Workers.
The community as co-producers of their own health; the experience with community quality improvement teams in rural eastern Uganda.

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ABSTRACT

The community as co-producers of their own health; the experience with community quality improvement teams in Rural Eastern Uganda. Rogers Mandu1, Monica Okuga1,, Darius Kajjo1,, Hudson Balidawa2, Stefan Peterson1,3, Peter Waiswa1,3

Introduction: Despite various efforts in ensuring that mothers and their newborns survive through a number of interventions in Uganda over the last decade, maternal and newborn health coverage indicators remain poor despite the existence of a multitude of evidence-based, affordable and appropriate interventions. Demand and supply factors critically determine coverage and effectiveness of interventions and opportunities to prevent and treat poor health. Study objective: To improve maternal and newborn health care through expanded quality management approach that links communities to health facility services powered by locally generated high quality health data at the community level.

Methods: The intervention uses the power of Community Quality Improvement teams (cQITs) to locally generate data that captures all pregnant women in the parish and establish their level of preparedness for birth; hindrances towards birth planning are identified through consensus in community meetings with the community members. The possible solutions known as 'change ideas' are first tested using the plan-do-study-act (PDSA) model on a small scale before they spread to larger areas. Results and lessons learnt: A pattern of events, detailing the different change ideas tested by the community quality improvement teams resulted into improvement. Birth preparedness increased from 30% to 70% in the first quarter of implementation. Home visits were used for some time to identify and verify with the pregnant women and seen not to be giving positive results; another change idea of birth preparedness checklist was tested, subsequently communities formed women's savings groups as a model to mobilising communities to reduce care seeking delays.

Conclusion: It is feasible for community health workers to implement continuous quality improvement, as this improves birth preparedness for maternal and newborn care.
The accessibility of after-school sexual and reproductive health programmes and health services for adolescents: Findings from the prepare RCT in Cape Town

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ABSTRACT

Background After-school sexual and reproductive health (SRH) education programmes and health services for adolescents are extra-curricular and voluntary. In designing such services it is important to know the extent to which they are accessible to adolescents at highest risk of adverse SRH outcomes. South Africa is revising the school health services for children and adolescents, and it is likely that parts of the service will be offered after school hours. We investigated whether an after-school SRH education programme and school health service attracted adolescents most at risk of adverse SRH outcomes. We considered adolescents as vulnerable if they reported an early sexual debut, had been exposed to sexual and/or intimate partner violence, or if they were at risk for mental disorders. Methods We invited adolescents in Grade 8 (mean age 13.8 years) in 20 schools participating in the intervention arm of an HIV prevention cluster RCT in Cape Town, to participate in an after-school SRH programme. We surveyed them at baseline, and in intervention schools measured participants attendance 21 weekly after-school intervention sessions prospectively over 6 months. Results Among 1576 adolescents allocated to intervention schools, the mean attendance was 8.8 sessions (SD 7.5) among girls and 6.9 (7.2) among boys, and 17.3% (14.9% of boys and 18.7% of girls) visited the school health service. The factors associated with a lower rate of attendance of the education sessions were being male, older, having repeated a school year, reporting delinquent behaviours, having attempted self-harm, ever having had sex, and being a perpetrator of IPV. Conclusions The after-school programme was accessible to some of the most vulnerable adolescents: young women. However, when considering several other categories of risk such as early sexual debut, those most vulnerable had lower rates of attendance. These findings are important for the design of accessible school health systems.
Can community health officer-midwives effectively integrate skilled birth attendance in rural areas?
Evidence from Northern Ghana

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ABSTRACT

Background: The burden of maternal mortality in sub-Saharan Africa is enormous. In Ghana maternal mortality ratio was 350 per 100,000 live births in 2012. Skilled birth attendance has been shown to reduce maternal mortality and morbidity, yet in 2010 only 68% of mothers in Ghana gave birth with the assistance of skilled birth attendants. In 2005, the Ghana Health Service piloted a strategy using the Community-Based Health Planning and Services (CHPS) program and training Community Health Officers (CHOs) as midwives to address the gap in skilled attendance in rural Upper East Region. The study assesses the extent to which the skilled delivery program has been implemented as an integrated component of the existing CHPS. Method: We employed an intrinsic case study design with a qualitative methodology and conducted 41 in-depth interviews with health professionals and community stakeholders. We used a purposive sampling technique to identify and interview our respondents. Results: The CHO-midwives provide integrated services that include skilled delivery in CHPS zones. The midwives collaborate with other stakeholders and communities to offer skilled delivery services in rural communities. They refer pregnant women with complications to district hospitals and health centres for care, and there has been observed improvement in the referral system. The CHO-midwives are provided with financial and non-financial incentives to motivate them for optimal work performance. The primary challenges that remain include inadequate numbers of CHO-midwives, insufficient transportation, and infrastructure weaknesses. Conclusion: Our study demonstrated that CHOs can successfully be trained as midwives and deployed to provide skilled delivery services at the doorsteps of rural households. The integration of the skilled delivery program with the CHPS program appears to be an effective model for improving access to skilled birth attendance in rural communities of the UER of Ghana. Keywords: Community-Based Health; Ghana; Maternal Mortality; Skilled Attendants at Birth
Bottlenecks in health systems for community-based emergency referral for maternal newborn and child health in Myanmar

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ABSTRACT

Background: Community-based emergency referral for Maternal Newborn and Child Health (MNCH) was established by formation of Village Health Committee (VHC) in Middle Island after the Cyclone Nargis with funding support from Save the Children Non Governmental Organization. Villages in Middle Island are hard-to-reach area in Ayeyarwaddy Region. The main aim of VHC is to improve emergency referral for MNCH in those hard-to-reach areas. The study aims to identify success, challenges and barriers in health systems at the community level for emergency referral for MNCH in Myanmar. Methods: The operational research was conducted in six villages of Middle Island, Nga-Pu-Daw Township, Ayeyerwaddy Region, Myanmar in 2013. Six Focus Group Discussions, 12 in depth interviews, 18 key informant interviews were conducted. Data analysis was conducted according to main themes and sub-themes with assistance of ATLAS ti version 6.0 software. Results: Access to and utilization of government health service was improved after the formation of VHCs. Coordination at all levels from central level to sub-Rural Health Center (RHC) level in initial phase of the project was the main factor for success of this mechanism. However, whether community would go and utilize government health service in case of emergency if there is no support (support for travel cost and supports at hospital) is questionable. Success of this community-based referral is strongly linked with functioning health systems at the grass-root level and capacity of Basic Health Staff (BHS). Challenges in health systems’ attitude of BHS, facility and capacity of health staff at Station Hospital, motivation and incentives for BHS and volunteers from sub RHCs and RHCs were also identified. Conclusion: The study highlighted some barriers in health systems hinder the success of community-based emergency referral. Well functioning health systems plays pivotal role to gear up this community-based activities in other townships of Myanmar.
Factors influencing sustainability of community-based health volunteers' activities in the Kassena-Nankana East and West Districts of Northern Ghana

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ABSTRACT

ABSTRACT Background: An increasing demand for health care services and getting health care closer to doorsteps of communities couple with the shortage of formal health care providers made health service managers to resort to seeking greater collaboration with communities and the use of non-professional health workers to provide health services to people in rural communities. Community volunteerism in Ghana has been identified as an effective strategy in the implementation of Primary Health Care activities. The challenge however, is how to sustain volunteer activities. This study therefore aims at exploring factors influencing performance and sustainability of health volunteer activities in the Kassena-Nankana East and West Districts in northern Ghana. Methods: Cross-sectional survey design and qualitative research methods were used to gather data. Two hundred (200) structured interviews were conducted with volunteers and 14 in-depth interviews with health volunteers and health workers involved in volunteer activities in the two districts. Bivariate and multivariate regression analyses were used to determine factors affecting performance and retention of health volunteers. Results: The overall assessment of performance of volunteers showed that 45% of them scored high on performance. Factors affecting performance in the multivariate model were education [OR=4.64 95% CI (1.22-17.45)], ethnicity [OR=1.85 95% CI (1.00-3.41)] and occupation [OR=6.27 95% CI (1.39-28.26)]. In the bivariate model, means of transport [OR=3.70 95% CI (1.44-9.54)] was an intermediary factor affecting performance. Also 80.5% reported motivation/incentives such as raincoats, torch light and wellington boots as retention mechanisms to sustain volunteer activities but only means of transport [OR=3.30 95% CI (1.26-8.68)] was significant in retaining and sustaining volunteer activities. Conclusion: Providing basic means of transportation and non monetary motivation like raincoats torch light and wellington boots will motivate volunteers to perform better, sustain their activities at the community level and also sustain the primary health care vision.
China's rural public health system performance

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ABSTRACT

Background In the past four years, the Government of China initiated health reform with rural public health system construction to achieve equal access to public health services for rural residents. The study assessed trends of public health services accessibility in rural China from 2009 to 2011, as well as the current situation about the China’s rural public health system performance. Methods The data were collected from a cross-sectional survey conducted in 2012, which used a multistage stratified random sampling method to select 12 counties and 118 villages from China. Three sets of indicators were chosen to measure the trends in access to coverage, equality and effectiveness of rural public health services. Data were disaggregated by provinces and by participants: hypertension patients, children, elderly and women. We examined the changes in equality across and within region. Results China’s rural public health system did well in safe drinking water, children vaccinations and women hospital delivery. But more hypertension patients with low income could not receive regular healthcare from primary health institutions than those with middle and high income. In 2011, hypertension treatment rate of Qinghai in Western China was just 53.22% which was much lower than that of Zhejiang in Eastern China (97.27%). Meanwhile, low performance was showed in effectiveness of rural public health services. The rate of effective treatment for controlling their blood pressure within normal range was just 39.7%. Conclusions The implementation of health reform since 2009 has led the public health development towards the right direction. Physical access to public health services had increased from 2009 to 2011. But, inter- and intra-regional inequalities in public health system coverage still exist. Strategies to improve the quality and equality of public health services in rural China need to be considered.
Empowering community on antibiotic resistant issues: Experience from university - Civil society organization partnership in Malaysia

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ABSTRACT

Objectives: To assess the knowledge of community towards issues related to antibiotic resistance (ABR).

Methods: A community based case study approach was adopted. Participants were all the community leaders who came from 34 local settlements in the state of Penang Malaysia. Participants were given information related to ABR issue via didactic lecture and open discussion by the study authors. A pre and post assessment of the participants knowledge towards issues related to ABR were assessed using a prevalidated questionnaire. Results: A total of 29 community leaders were involved in the programme. 23 (79.3%) of them participated in the pre assessment while only 12 (41.4%) of them that participated in the post assessment. Post assessment shown that 61.5% of participant disagreed antibiotics able to treat viral infections compare to pre assessment in which 91.3% of them believe oppositely. 34.8% of participants will stop taking antibiotics when their symptoms are gone. But, the percentage decrease (15.4%) after the programme. The percentage of participants expecting antibiotics to be prescribe by the doctor if they fall sick also decrease after the programme, from 47.8% to 30.8%. Conclusions: A novel programme is needed in order to enhance community knowledge towards the issues related to ABR. Important message regarding this issues can be relayed directly to community and thereby shift their old perception and knowledge towards the new view on rational use of medicines. Thus, educating the community should start from the grassroot level by approaching directly to the individuals in the community, especially the leaders as they we respected by the society and can play an important role towards the succeed of the goal.
The effectiveness of two innovative community health systems strengthening models to improve uptake of proven maternal, newborn, and child health interventions in remote areas of Burundi and Honduras

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ABSTRACT

Community health system strengthening (CHSS) is a key strategy endorsed by many governments in low resource countries to help them achieve improved, equitable, and sustained health outcomes. However, there is limited evidence on how CHSS systematically works across settings to improve availability, demand, and use health interventions, and ultimate outcomes, especially for vulnerable populations. This paper analyzes results from operations research (OR) studies that tested the effectiveness of two innovative CHSS models - Care Groups and Community Health Units (UCOs) - implemented in Cibitoke province, Burundi and in Francisco Morazán department, Honduras, respectively. Both models aimed at strengthening community linkages with the formal health systems for improved and sustained access to maternal and child health services. Data from two OR studies conducted between 2009 and 2013, both using pre-posttest surveys with intervention and comparison groups were used. We also used qualitative data obtained through key informant interviews at end-of-projects to explain how the strategies worked and their impact. Specifically, we compared the percentage of women who were assisted by a qualified health worker (doctor, nurse or auxiliary nurse) in their delivery and those that sought support of health workers when their children had fever. The results show that both approaches were effective in improving health outcomes - skilled birth attendance and health seeking behavior for children. Nonetheless, the analysis also showed that the strategies themselves were not clearly defined in terms of what was implemented to allow for replication. Based on these findings there is a need to develop measures for systematically assessing CHSS effects on improving the reach of the national health system and health outcomes as well as generating comparable data across program implementations to improve practice. We recommend that researchers work closely with organizations implementing community-level interventions to refine such measures and tools for ongoing learning.
Financial protection and Social inclusion in health care: empirical evidence regarding the performance of community-based health care financing in Cote d'Ivoire.

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ABSTRACT

Community-based health financing has been attracting increasing attention as a potential instrument for protecting low-income populations from the impoverishing effects of health care expenditures. Proponents argue that communities have incentives as well as instruments to reach the poor and the socially excluded. In contrast, general tax- and social insurance-funded health care structures often lack instruments to achieve close targeting of the poor and ensure their financial protection at the time of illness. The objective of this paper is to provide empirical evidence regarding the performance of community-based health care financing in terms of social inclusion and financial protection. Two non-standardized household surveys were analyzed from Cote d'Ivoire. Common methodology was applied to the two data sets. Logistic regression was used to estimate the determinants of enrolling in a community-financing scheme. A two-part model was used to assess the determinants of financial protection: part one used logistic regression to estimate the determinants of the likelihood of visiting a health care provider; part two used ordinary least-squares regression to estimate the determinants of out-of-pocket payments. Our findings suggest that community financing can be inclusive of the poorest even in the most economically deprived context. Nevertheless, this targeting outcome is not automatically attributable to the involvement of the community; rather it depends on key design and implementation characteristics of the schemes. For financial protection, community financing reduces financial barriers to health care as demonstrated by higher utilization and simultaneously lower out-of-pocket expenditure of scheme members controlling for a range of socioeconomic variables. Design and implementation characteristics of community-financing schemes matter in achieving good targeting outcome; community involvement alone does not guarantee social inclusion. Further research is needed to delineate which design and implementation characteristics allow better inclusion of the poor. Prepayment and risk sharing, even on a small scale, reduce financial access barriers.
Cost-effectiveness of national program on non-communicable diseases in a low-middle income country and efficiency analysis of various scale up scenarios: Study protocol

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ABSTRACT

Introduction: India has responded to rising burden of Non-Communicable Diseases (NCD) by initiating a national programme for NCD control. Mid and long term targets under the program have been laid down for controlling NCDs. Though financial estimates have been prepared for implementation of program but how much will be the effects of implementing the program at current costs in current scenarios and will country be able to achieve the set targets at current level of spending are the key questions that need to be answered. We have therefore proposed to conduct a Markov model based cost effectiveness analysis of this programme. We aim to present and discuss the rationale behind the proposed study, the materials and methods we are planning to use and expected outcomes from the study for the benefit of researchers from our and other low and middle income countries. Rationale: The proposed research is highly policy relevant in light of current nature of debate on achievement of MDGs. The cost estimates and cost effectiveness analysis can act as a way forward to successful achievement of NCD 25Ã—25 targets in coming years. Methodology: The research question will be answered from a societal perspective. Effectiveness of different interventions will be reviewed from literature. Effectiveness will be modelled in terms of gain in disability adjusted life years (DALY). Interventions will be evaluated relative to a counterfactual epidemiological situation of doing nothing as against implementing the specified-interventions at the specified levels of coverage. The simulation exercise will be applied to the period 2010-2025, coinciding with the end year of achieving 25X25 targets. Study Outcomes: 1. Incremental cost per patient, under program against a comparator of 'No intervention'. 2. Incremental cost per unit reduction in DALYs, under program against a comparator of 'No intervention'. 3. Incremental costs by year from 2013-2025 for different intervention packages, in all the scenarios of scale up.
Implementation of the free cesarean section policy in Benin: Did it work, for whom and why (not)?

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ABSTRACT

In many countries, the maternal mortality ratio decreases too slowly to reach the MDGs. While effective strategies are well documented, little is known about the mechanisms that lead to implementation failure at the local health system level. In Benin, the free caesarean section (C/S) was introduced in 2009, reimbursing hospitals US $ 150 per C/S. Evaluations showed that its implementation was widely variable, but failed to explain why. Within the FEMHealth project, we carried out a realist evaluation to assess how the policy was implemented in 7 hospitals. We explored the mechanisms and conditions that explain the adoption of the policy. The starting point was an initial programme theory based on a review of the policy implementation literature and field experience. Data were collected through interviews with key respondents (including community representatives) and document reviews (including routine data). We found limited ownership of the policy by key stakeholders, resulting from the lack of clear policy documents and guidelines, inadequate communication and uneven support by the central agency that was responsible for implementation. In general, local health system managers adopted the policy formally, following a principle of parsimony of effort. A predominant organisational culture of 'laissez-faire' and inadequate stewardship was found to contribute to limited adoption of the policy by health providers and in some cases to its capture for personal benefit. We found only in a few cases that local managers pro-actively adapted their organisational routines to the policy requirements and inversely adapted some aspects of the policy to the local context for the full benefit of the target group. We conclude that the implementation of a health policy is highly dependent not only on health service managers and providers, and organisational and community-level factors, but also a strong stewardship capacity that goes beyond mere strategic management and leadership.
Community level health systems through the eyes of youth: Findings from using photovoice to examine maternal health in central Uganda

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ABSTRACT

Background Uganda has experienced several challenges affecting maternal health for many years. Maternal mortality rate is currently at 310 deaths per 100,000 live births. Health system challenges that underpin these outcomes include low awareness, lack of access, and poor quality of care when available. Youth are an untapped resource that could contribute to addressing these challenges particularly in rural areas. The study explored the perspectives of youth on the health system’s problems that underpin maternal health in rural communities in Uganda. Methods The study used photovoice as a community based participatory research approach. 10 diversely selected youth aged between 18 & 29 years from 5 villages in Wakiso district, Uganda were trained how to use cameras then assigned to take photos for 5 months of situations related to maternal health. Monthly meetings were held to discuss the photos taken and identify the emerging issues from the research. Community dialogues were also held to discuss experiences and learnings at the end of the project. Results The photographs, ensuing group discussions and community dialogues confirmed the continuation of known health systems problems. These included long distance to health facilities, inadequate transport, waiting for long hours at health facilities, poor health worker attitudes and absence of health workers at facilities. By empowering youth to spend time immersed in their communities documenting and discussing maternal health issues, other aspects of health systems that need to be addressed also arose. These social determinants and intersectoral concerns affecting maternal health in the community included nutrition, education, domestic violence, unemployment, alcoholism, drug abuse, male involvement, water, sanitation, income generation, agriculture, housing and the work environment. Conclusion Moving beyond recognized health systems problems, youth through photovoice also highlighted important social determinants and intersectoral concerns that are key to defining health systems at community level and in addressing maternal health.
Identification of bottlenecks to improvement of a supervision system for community health workers: a qualitative study on community IMCI in Timor Tengah Selatan, Indonesia

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ABSTRACT

Background: Many developing countries have demonstrated the success of community-based Integrated Management of Childhood Illnesses (cIMCI), reducing child deaths by enabling lay community health workers (CHWs) to treat major childhood diseases. UNICEF has been supporting this approach since 2010 in four pilot districts in eastern Indonesia. Recent reports suggest that more effective supervision of CHWs is needed.

Method: A qualitative study with an interpretative approach was undertaken to identify possible bottlenecks to effective supervision of CHWs in Timor Tengah Selatan (TTS) district in East Nusa Tenggara, Indonesia. Key-informant interviews with seven health staff with supervisory roles and seven CHWs were carried out in three health centres and seven villages. In-depth interviews were conducted to explore their perspectives towards effective supervision and thematic content analysis was used to interpret the results.

Results: Both supervisors and CHWs perceived that better supervision would improve motivation and performance, thereby improving child healthcare. Bottlenecks identified were lack of guidelines and misconceptions about supervisory tools. Improving communication between supervisors and CHWs and adequate knowledge level of CHWs were considered critical for effective supervision. Other obstacles include gaps in drug supply, transport and time constraints. Participants cited the need for incentives, refresher training, intensified supervision and careful selection of CHWs as key towards effectiveness.

Discussion: Effective supervision is a critical factor for delivering community IMCI. Policy and guidelines are needed to formalise and further define the role of CHWs in providing care in the community. The role of supervisors should be specified and supported by the health system by integrating supervision into the official duties of formal health sector workers.
Awareness about Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) in India

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ABSTRACT

Background In 2008, India launched social health protection initiatives called Rashtriya Swasthya Bima Yojana (RSBY)- a fully subsidized National Health Insurance programme for BPL (Below-Poverty-Line) households. Awareness is the first step towards enrolling and later utilising the benefits. The objectives of the study were to identify how many BPL households were aware about RSBY and to assess their depth of awareness, to explore factors influencing the awareness and to compare the results between Maharashtra and Karnataka because of different experience of implementing RSBY. Methods The data collection was done during 2012-2013 using mixed methods. In Maharashtra, 22 districts were selected with multi-stage sampling for the cross-sectional survey covering 6000 households along with 16 focus-group-discussions and 34 in-depth interviews with stakeholders in five districts. In Karnataka, the study was conducted across four districts involving repeated household surveys of 6040 eligible households along with 23 focus-group-discussions and 32 in-depth interviews with different stakeholders involved in implementation of the scheme. Results The preliminary results reveal that the awareness about RSBY among BPL households is 29.7% in Maharashtra and 51% in Karnataka. Few factors (like residence, sex, caste, etc) are related to awareness. The aware households had higher enrolment rate but the depth of awareness was quite poor. They had incomplete information on scheme which is a barrier in utilization of benefits. The key informants reinforced these findings stating that the strategies and efforts for creating awareness of RSBY among the BPL households are not consistent. Discussion/Conclusions The proportion of awareness of RSBY among BPL households is low affecting their enrollment and utilization of benefits. It is important to to invest more resources and proactively create in-depth awareness rather than just familiarity among the vulnerable sections. Anyone should understand and use given information. There is a need to implement the campaign for creating awareness professionally with more creative and multiple strategies.
Unit cost analysis of training a community health worker in Tanzania

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ABSTRACT

Background: Tanzania, as well as other African countries, faces health workforce shortages. The Ifakara Health Institute and the Tanzania Ministry of Health and Social Welfare developed the Connect project as an experimental trial of the deployment of a cadre of community health workers and their impact on health outcomes in selected rural communities. Connect aims to test the hypothesis that community-based primary health care services can accelerate the achievement of Millennium Development Goals 4 and 5. This paper presents an estimation of the costs associated with the training of Connect's Community Worker (CHWs) to inform potential scale-up of the cadre.

Methodology: Data were collected through project activity tracking and in-depth interviews with key informants involved in the training of CHW and public clinical training centre.

Results: Result shows that the program training cost was US$2,489 per CHW, of which meals accounted for 40%, accommodation accounted for 20%, and training facilitation accounted for 18%. The total modeled unit cost during scale-up and utilizing regional clinical training centres was estimated at $833 USD per CHW. The $833 constitutes 50% for meals costs, 27% for training fees, 14% for field allowances, 6% for accommodation, and 3% for medical insurance.

Conclusion: Due to the limited resources available, it is recommended that training of CHWs should be conducted through training centres at the regional level since it reduces costs by 66% compared with the program model.
Can training and supportive mentoring assist community caregivers to improve uptake of key maternal and child health services for mothers and children in the household?

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ABSTRACT

Background Community caregivers (CCGs) are key in improving coverage of community-based services for mothers and children. This study aimed to evaluate whether training for CCGs to provide services to mothers and children in the household together with mentoring could improve uptake of services. Methods A cluster randomised trial was conducted in one district of KwaZulu Natal, South Africa over a period of 12 months. Intervention CCGs received 2 weeks of maternal and child health training followed by regular 2 weekly mentoring sessions using a continuous quality improvement approach, facilitated by a trained quality mentor (QM). Focus group discussions and in-depth interviews were conducted with CCGs and QMs at mid and project end to explore their experiences of the training and mentoring. Results CCGs found the training along with the regular mentoring sessions to be beneficial in terms of translating what they had learned to their work at a household level. CCGs reported that they had previously received minimal support and supervision and that they now felt valued and supported in their work due to the mentoring sessions. In the mentoring sessions CCGs were expected to identify a problem that they were experiencing in the community, interrogate the problem and develop an intervention for the problem. CCGs reported learning from each other in the sessions and working together to identify and solve problems encountered at a community level. The mentoring sessions have also equipped the CCGs with skills to understand and interrogate data collected at a household level. Conclusions CCGs are essential in providing the link between communities and primary health care facilities. Training, on-going supportive supervision and mentoring are beneficial to CCGs in the learning process and are essential to the success of community based interventions.
The reception of village malaria workers in rural Cambodia: knowledge, perceptions, and preferences in user communities.

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ABSTRACT

BACKGROUND: Despite sustained efforts to strengthen the health system and significant progress, Cambodia still suffers from critical shortages of health professionals and inequities in the distribution of health services. This problem is particularly acute in remote areas, where the incidence of infectious diseases such as malaria and typhoid fever is higher, where access to health facilities may be limited by environmental barriers, and where poor communities bear the greatest economic burden of illness. Over the past decade, the deployment of lay members of the community to provide basic medical services amongst the most vulnerable populations has been one of the key interventions to address this problem. METHODS: We conducted a qualitative study to examine the reception and impact of the Village Malaria Workers (VMW) programme in Cambodia, a community-based intervention to support the management of malaria cases and childhood illnesses. Methods included observations and in-depth interviews (n=80) in user communities. A thematic question guide with open-ended questions was used for the interviews. Thematic content analysis was then conducted to explore factors that may promote or discourage service utilisation. RESULTS: Many respondents thought that VMWs can deliver appropriate medical care and services, but some expressed a preference for private providers as these were seen to offer more comprehensive and qualified health care. Many respondents had inadequate awareness of VMWs and the range of services they provide. DISCUSSION: Findings from our study point to the need for innovative communication strategies to increase the utilisation of VMWs. We argue that investment in symbols and visual communication tools are required to promote the visibility, status, and identity of health volunteers in user communities, also given current policy trends - in and outside Cambodia - towards an increasing use of community workers to perform roles and tasks that are conventionally associated with health professionals.
Validation of urdu version of resilience scale among married women of age 20 To 40 years living in urban squatter settlements of Karachi, Pakistan

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ABSTRACT

Background: Resilience is the core of promoting positive mental health. This concept widely studied in developed countries and less in developing countries. Further, no valid instrument exists in South Asia to assess resilience. Thus, the objective of the study was to assess the validity and reliability of the Urdu version of Wagnild and Young's long and short Resilience Scale(RS). Methods: The study was carried out in two urban squatter settlements of Karachi, Pakistan: Malir and Shah Faisal Town. Resilience Scale long and short was validated against the scales of depression, anxiety and life satisfaction among married women of age 20 to 40 years. The original English version of RS was translated into Urdu and the standard and rigorous procedure of back-translation was followed to ensure conformity across language versions. Six community health workers received four day training sessions for questionnaire administration. 636 community women were selected through systematic sampling for validity and half of the selected participants were randomly selected for reliability. Results: Mean age of the participants was 30.08 years (SD = 5.7). Both long and short RS were found to have moderate negative correlation with the depression and anxiety, and moderate positive significant correlation with life satisfaction. The test-retest correlation coefficients for the long and short were found 0.54 and 0.49 respectively. The Cronbach's alpha for both were also in an acceptable range. Furthermore, the concurrent validity showed the high positive correlation between both the scales. Conclusion: This study demonstrates that the Urdu version of RS has reasonable psychometric properties. Short scale was equivalent to the long one in all. Thus, this tool can serve as a feasible option for measuring resilience in the community and the two versions can be used interchangeably. Hence, the field dimension of this study is cutting-edge research around community based health services.
Factors influencing maternal health-seeking behaviour in rural Ethiopia: What are the opportunities for strengthening community-based health systems?

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ABSTRACT

Introduction: Many countries are investing in community-based health systems and community health workers. Ethiopia has high maternal mortality and low maternal health service utilization. In 2004 Ethiopia launched a Health Extension Program (HEP) which focuses on providing promotive, preventive and some basic curative health services to the community, including maternal and child health. In order to increase maternal health service uptake, we need to understand factors influencing health-seeking behaviour. This study aimed to identify community-related factors which affect maternal health-seeking behaviour in order to develop a quality improvement cycle to strengthen community-based approaches in Southern Ethiopia.

Methods: The study comprised a desk review and qualitative research. Primary data were collected at community level in 8 Focus Groups Discussions (FGDs) with women or men, 21 interviews with women, Kebele administrators and traditional birth attendants; provider level in 6 FGDs and 12 semi-structured interviews with health extension workers; 11 key informant interviews were conducted with health extension program coordinators, health centre heads and delivery case team leaders. Results: Multiple factors affected low uptake of maternal health services. Individual factors: prioritization of domestic or agricultural activities, desire to have more children, low perception of risks during pregnancy and delivery; family factors: lack of support from husbands, conflating advice from influential relatives; cultural practices: non-disclosure of early pregnancy, burying the placenta at home. Other barriers related to the health system/sector: lack of privacy, unwillingness to be seen by unacquainted health-workers, use of a delivery couch, worry about unfamiliar health facilities. Conclusion: Attempts to strengthen community-based maternal health services should be responsive to factors influencing health-seeking behaviour. Targeted awareness creation and community mobilization, specific training and support of HEWs to help women and their families to better negotiate the multiple barriers to care may improve service utilization as part of a quality improvement package.
Volunteering a quality death': Revisiting network neighborhoods in Kerala - palliative care movement

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ABSTRACT

Purpose This writing intents to highlight three observations: One, the possibility that community health actions can achieve its objectives even without external financial support; two; a successful community initiative can influence the government to be a party, with consensus-based policy framework, and third, the idea of 'public health' can be easily defend commodification and commercialization of health care if 'people facilitated' delivery systems are mainstreamed. Here, the Neighborhood Network Palliative Care (NNPC) model in Kerala is analyzed as an alternative to the hospice approach, which revolutionized the sector through empowering local communities to identify the terminally and/or chronically ill, regardless of disease or cause, to support them and families with self-sustainable community led services (social support, psycho-spiritual support, nursing care and partially medical-clinical management) without any external economic support. Focus NNPC offers an innovative alternate to the regurgitated medicalized approach as it led the state government to have first of its kind palliative policy in Asia, revise the essential drugs list and also to link the initiative with the National health system through National Rural health Mission (NRHM). The study critically examines the nuanced questions like maintaining community participation and volunteering when the State takes responsibility for palliative care, the concerns about the involvement of political society in what has erstwhile been considered a civil society domain and establishing and mentoring the standards and quality of care at low cost. Significance Palliative Care deserves an urgent public health priority. The significance lie in the facts that social and economic factors are far more important to what kind of death we face, than purely medical, and also from the understanding that palliative care is highly marginalized within the medical establishments, and terminal care and death can be easily commercialized, which may hinder the â€“ quality of death' of many!
Enablers and barriers in scaling up of the Home Based Newborn Care (HBNC) programme in Southern states of India

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ABSTRACT

Background: The HBNC model was developed by SEARCH through a ground-breaking trial conducted in one of the remotest districts in India. The state government of Karnataka introduced the programme as one of the key interventions to improve newborn care and survival in the state, long before the Government of India adopted it as a national programme. Objective: To bring out enablers and barriers in scale-up of HBNC delivered through Accredited Social Health Activists (ASHAs) in the state of Karnataka. Method: Sixteen villages randomly selected through multi-stage sampling from four districts representing south and north Karnataka as well as where both SEARCH and NRHM models of HBNC were being implemented. In-depth interviews with beneficiaries, ASHAs, Auxiliary Nurse Mid-wives and health officials at different levels were conducted in October -December 2012. Results: There was minimal difference between SEARCH and NRHM models in content and quality of implementation. However the difference between north and south Karnataka was stark, owing to variance in health infrastructure and human resource. There was no exclusive cadre for HBNC at any level, or any well-defined system for supervision, monitoring or remuneration. District level health personnel implicitly conveyed a perception that ASHAs were not a part of the formal health system, and equally understood so by ASHAs, thus giving ASHAs a low professional status and limiting their capacity in delivering HBNC. The programme was limited to health education and referral, but no other tangible care was given by ASHAs. The HBNC training was taking place, but the follow-up supervision, logistic supply and maintenance, and monitoring was weak. Discussion: A successful implementation of scale-up programme depends on the quality of the established health system. The formal health system has to convey a stronger sense of ownership on ASHAs as a cadre. Follow-up actions subsequent to training need to be focused.
Evaluation of a community case management of malaria program in Burkina Faso

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ABSTRACT

Background. Malaria is holo-endemic in Burkina Faso and causes the death of approximately 40,000 individuals every year. In 2010, the health authorities introduced community case management of malaria. In every village a community health worker (CHW) was selected and trained to promptly administer treatments to febrile cases. The objective of the study is to evaluate under real-life conditions of implementation the program’s impact on health-care seeking practices of sick children. Methods. We used a repeated cross-sectional design. The study area is located near the city of Kaya. We randomly selected 2000 households from the population living within a 15-kilometer radius of Kaya’s sampling was stratified by the setting (rural vs. urban area). Each household was visited once a year during the season of high-transmission of malaria (August 2011, 2012 & 2013). Household surveys were administered and health-seeking practices of sick children who had recently been sick were documented. Results. The uptake of CHWs by children under five years of age was very low. In the urban area, less than 1% of sick children were brought to a CHW. In villages, this proportion reached 6% in 2011, 5% in 2012 and 9% in 2013. The most frequent reasons for not visiting the CHW were the preference for the health center and the fact that the mother did not know the village’s CHW. The removal of user fees in health centers for children under five in August 2011 is associated with a reduction of the propensity to visit a CHW. Conclusion. The program is unsuccessful in the urban area. In rural areas the uptake of CHWs is low compared to other programs implemented in similar contexts. A concomitant local intervention might have reduced CHWs’ uptake.
Home-based counselling by community health volunteers to improve newborn health and survival: A cluster-randomised trial in rural Tanzania

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ABSTRACT

Background Newborn mortality rates are high and have only slightly declined in the past years. Home based counselling has been shown to improve neonatal survival in south east Asia. Here we report results of a cluster-randomised trial of a home based counselling intervention for neonatal health in a rural African setting.

Objectives We used a volunteer village based community health workers to do home visits during pregnancy and immediately after childbirth to counsel mothers and other family members on behaviours expected to improve newborn health and survival. The targeted behaviours include hygiene during delivery, immediate and exclusive breastfeeding, and both identification and action for low birth weight babies. Additional messages included birth preparedness, warmth for newborns and knowledge of danger signs.

Methods Wards in 6 districts of Lindi and Mtwara regions were randomised to intervention or comparison groups. In 2013, three years after full implementation, we carried out an endline household survey in 185,000 households including interviews with all women aged 13 to 49 years regarding their recent birth history and including detailed information about pregnancy, childbirth and the newborn period for all births in the previous year.

Results Effects of the intervention on pregnancy care, intrapartum care, and newborn care will be presented, as well as effects on newborn survival. Preliminary findings suggest large increases in facility deliveries from 41% in 2006-7 to around 80% in 2013. Conclusion Integration of the approach in primary health strategy is paramount in reaping the potentials to further impact on community health. The experience from the approach has contributed to the development of national guideline for community health initiatives in Tanzania.
Voices and experiences of front line health workers in Malawi: Strategies and opportunities to better support community based health systems

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ABSTRACT

Background: Malawian Health Surveillance Assistants (HSAs) play a key role in delivering health services at the front line in communities in a broader national context of acute shortages of human resources for health. This study aimed at understanding and analysing the perspectives and challenges faced by HSAs, bringing their voices into the debate on health systems and into the design of ongoing quality improvement cycles in order to strengthen community-based health systems. Methods: Qualitative research using focus Group Discussions and semi-structured in-depth interviews was conducted in two districts in the central region of Malawi: Mchinji and Salima. Study respondents included: mothers with children under five years of age, health workers including HSAs officials working for the District Council and non-governmental organisations. A stakeholder analysis was also conducted and fed into the qualitative analysis process. Results: HSAs play a pivotal role as a bridge between health systems and communities. Challenges faced by HSAs include: the role of allowances and the need for coordination, support and supervision. Incentives were motivating; HSAs who felt side-lined by those in charge of allowances opted not to dedicate themselves to the tasks at hand but seemed more devoted to activities that promised more allowances. Supervision structures for HSAs were in place; however supervision was mostly not done due to inadequate financial and human resources. Most HSAs reported getting feedback only when something went wrong with their work. Supervision was uncoordinated, was mostly one-way and unsupportive. Conclusion: HSAs are embedded at community level play a vital role in linking health systems and marginalised communities. Their voices and experiences need to be considered and acted upon to build equitable and sustainable community based health systems. There is a need to address the multiple concerns of HSAs through coordination, transparent and accountable approaches to incentives and supportive supervision.
Cost and package of essential maternal and newborn health services for the poor and ultra-poor in remotest areas of Pakistan

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ABSTRACT

Rationale: Like many countries Pakistan has also developed an essential maternal and child health package of services. This includes a wide range preventive, basic and compressive EMONC services. However neither the financial implication of this services package is ever worked out. Nor did any concerted efforts made to ensure that these services are provide free of cost to the target communities. We developed a bare minimum services package for the poorest of the poor, estimated its cost and provide budget impact of this package to the public exchequer in Gilgit Baltistan region of Pakistan. Methods: Literature search was carried out on essential MCH services packages. Expert panel was formulated to devise an essential MNH package by reviewing different package and MCH and demographic, health and socio-economic data of Gilgit Baltistan. Social an economic data was reviewed to identify poor and ultra-poor population in Gilgit Baltistan. Maternal and newborn health (MNH) needs were estimated using the current population estimates for pregnant women, expected number of pregnancies, normal and complicated deliveries and neonatal care etc. Findings: The expert panel proposed essential MNH services package for the poor (28%) and ultra-poor(5.5%) in GB. The package of services included four antenatal visit, institutional based delivery and three postnatal visits. The cost of the package was estimated between PKR 12000 for normal delivery and PKR 25000 for C-section delivery. One year financial implication of this package of services was PKR2.7 million for a village of ten thousands population. The scaling up would require PKR49.7 million a year to provide financial protection to the poor and ultra-poor families of the GB region. Conclusion: The package of services and its cost are based on the current poverty incidence and MNH needs of the population. The success of scaling up this package however would require parallel efforts on improving efficiency transparency and accountability of healthcare delivery system in Gilgit Baltistan region.
Impact of an integrated community case management programme on uptake of appropriate diarrhoea and pneumonia treatments in Uganda: A propensity score matching and equity analysis study

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ABSTRACT

Background Pneumonia and diarrhoea disproportionately affect children in resource-poor settings. Integrated community case management (iCCM) involves community health workers treating diarrhoea, pneumonia and malaria. Studies on impact of iCCM on appropriate treatment are limited. The effect of iCCM as the first point of care on equity and uptake of appropriate treatments for pneumonia and diarrhoea was assessed among children aged 2-59 months. Methods Cross-sectional household survey data were examined for socioeconomic inequalities in treatment uptake and use of iCCM for pneumonia and diarrhoea using Erreygers’ corrected concentration index (CCI). Propensity score matching methods were used to estimate the average treatment effects among the treated (ATT) for children treated under iCCM with recommended antibiotics for pneumonia and ORS plus or minus zinc for diarrhoea Results Overall, more children treated under iCCM received appropriate antibiotics for pneumonia, (ATT=34.7%, SE=5.3) and ORS for diarrhoea (ATT=41.0%, SE=8.6) compared to children not attending iCCM. No increase was observed for children receiving ORS-zinc combination (ATT= -0.123, SE= 0.085). No inequalities were observed in uptake of appropriate treatment for pneumonia (CCI= -0.070; SE=0.083) and diarrhoea (CCI= 0.199; SE=0.118), nor in use of iCCM for pneumonia (CCI= -0.099; SE=0.073) or diarrhoea (CCI= -0.073; SE=0.085). Conclusions iCCM is an equitable strategy that significantly increases uptake of appropriate antibiotic treatment for pneumonia and ORS for diarrhoea, but not the uptake of zinc for diarrhoea. For maximum impact, interventions increasing zinc uptake should be considered when scaling up iCCM.
Community caregiver provision of maternal and child health services at a household level: overcoming challenges of trust and acceptability in KwaZulu Natal, South Africa.

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ABSTRACT

Background: Community caregivers (CCGs) can be significant role players in providing maternal and child health (MCH) services at a household level. However, CCGs face complex challenges when working within the community. This study aimed to evaluate whether MCH training for CCGs coupled with supportive mentorship can improve uptake of key MCH services. Methods: Eight focus group discussions (FGDs) and 12 in-depth interviews were conducted with CCGs to explore their experiences of visiting mothers in households. Twelve in-depth interviews were conducted with mothers to explore their experiences of CCGs visiting their households to give them advice in the antenatal and postnatal period. Results: CCGs and mothers reported initial difficulties around trust and acceptance when visiting households as mothers doubted CCG knowledge of maternal and child health issues and their ability to keep information confidential. Relationships between CCGs and mothers did, however, improve with time. Mothers began to trust CCGs as they realised that CCGs were equipped with knowledge that could help them and their babies' health in the antenatal and postnatal periods. CCGs were also equipped with a toolkit including thermometers, timers and MUAC tapes to monitor child health and this along with CCG referrals to the clinic were key in improving trust and acceptance. Mothers also began to trust CCGs as CCGs demonstrated that they did keep their information confidential. Through developing this relationship with mothers CCGs have seen improvements in uptake of exclusive breastfeeding, PCR testing and collection of results, early antenatal care attendance at the clinic and postnatal care visits at the clinic within 3-6 days. Conclusions: Lack of trust poses a major barrier to the success of community interventions. CCG knowledge and confidentiality are instrumental in building trust and acceptability in the community leading to uptake of services.
Integrating research, teaching and clinical care: Experiences from Sydney, Australia

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ABSTRACT

Background: The concept of an Academic Health Sciences Centre (AHSC) as a model for delivering cutting-edge healthcare in a research-intensive environment has been a feature of the North American landscape for many decades. The concept is far less developed elsewhere, including in Australia. The University of New South Wales has recently established four AHSCs as part of a larger 'Sydney Alliance for Healthcare, Research and Teaching' (SAHRT). Given that this was a novel initiative in Australia, we wanted to examine the process and elicit lessons for others who might want to establish similar alliances. Method: Nine in-depth interviews were conducted with senior academics and clinicians involved with the SAHRT. The project explored participant experiences, opinions and preferences for the future. For data analysis, we used established methods of qualitative research involving line-by-line coding for themes, synthesising codes into categories and abstracting to general analytic categories. Results: Overall, interviewees were optimistic about the potential of SAHRT as a vehicle to create a portfolio of collaborative research and funding and, to a much lesser extent, collaborative teaching and clinical care. They did, however, express a need for a very clear framework to guide strategies for working together and for connecting hospitals and universities; for a shared commitment to a purpose; for governmental and non-governmental support; and for early and realistic opportunities for tangible collaboration. Discussion/conclusion: Together these results point to the importance of considering entrenched cultural norms and values, power relationships and structural considerations when trying to establish new alliances in settings where these are not well-known. Systems in Australia have developed in such a way that individuals and small teams' with their particular moral, social and epistemic norms and structures' have been the locus of successful academic activities, and these will not be relinquished without clearly articulated, realistic and well-supported alternatives.
Agenda setting and rise and fall of policy issues: the case of maternity services in capitation benefit package.

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ABSTRACT

Background: The agenda for capitation as a method to give payment to health providers in Ghana was set at the inception of National Health Insurance Scheme as one of the payment systems to be explored. However, it remained dormant until it re-emerged with the decision to design and pilot a capitation payment system in the second populated region, Ashanti. Building on more than a year of preparation through planning, consultation and sensitization the pilot commenced in January 2012. The initial benefit package included maternity services for antenatal care, normal deliveries and post-natal care, but this was later removed during implementation. The aim of the study is to understand the policy discussions and politics surrounding the micro agenda setting for maternity services and the reasons for its inclusion and subsequent removal from the capitation pilot.

Methods: We used convergent voice and divergent voice frameworks to analyse data collected through interviews, documents, observations and media coverage.

Results and Discussion:

Inclusion in the agenda - The climate was ripe as the National Health Insurance Authority sought to contain claim costs especially for the delivery of primary health care. Proposed maternity services were bundled under the package as it was already provided at lower levels. As a policy issue it was legitimized as it gained immense political support from the government and the ministry of health. Going off the agenda - A strong competing voice emerged as provider groups made a case that maternal mortality would increase with capitation. Active and cohesive coalitions of providers, opposition politicians and some media practitioners with the interest to stop capitation was formed. It was among these networks that the policy issue was repeatedly reformulated, redefined, debated and alternatives proposed.

Conclusion: Unintended effects of intense lobbying by interest groups and over politicization of issues took maternity service off the capitation pilot.
Getting strategic about HRM': Designing human resource management 'bundles' to improve health workforce performance

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ABSTRACT

Background: Despite the importance of human resource management (HRM) to strengthening health systems, there is a lack of cutting-edge research on 'strategic' HRM and how health managers in resource-poor settings can use it to address workforce performance problems. High-performance models of strategic HRM advocate designing 'bundles' of linked and coordinated HRM strategies to improve workforce performance. These bundles should be (i) horizontally integrated with other HRM strategies and (ii) vertically integrated with wider health systems policies. This bundle design process requires both strategic thinking and systems thinking but raises two challenges: strategic HRM knowledge among health managers is limited in resource-poor settings, and there is an absence of primary research and guidelines on designing bundles.

Methods: The PERFORM project uses a participatory approach to strengthen district health management teams' (DHMT) capacities to improve workforce performance in Ghana, Tanzania and Uganda. Researchers facilitated short interactive workshops using tools and guidelines developed by the project (i) to support DHMTs to use workforce problem analysis techniques and (ii) to design HRM bundles using strategic HRM principles to address these problems. Findings: Although DHMTs demonstrated improved capacities to analyze workforce problems, the resulting workforce improvement plans showed DHMTs varied in their capacities to apply horizontal and vertical integration principles. This was due to: DHMTs' baseline HRM knowledge; initial challenges of learning to apply the project tools and guidelines; and challenges of identifying 'unintended consequences' when integrating HRM bundles with other health systems components.

Conclusions: PERFORM provides on-going facilitation to support DHMTs to modify and implement work plans, and to strengthen horizontal and vertical integration of bundles. Through documented learning, PERFORM is improving the tools and guidelines to enable other health managers in the study countries, and elsewhere, to apply strategic HRM principles to their management and planning to strengthen workforce performance.
Preferences on dual practice policies - evidence from a mixed methods study in Kampala, Uganda

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ABSTRACT

Introduction: In Uganda and other resource-constrained health systems, dual practice is a widespread government health worker coping strategy. A formal government policy on dual practice in Uganda does not exist. More broadly, little evidence exists on whether countries should have a policy on dual practice and what it should include. We explored the perspectives of key stakeholders on whether Uganda should have a dual practice policy, and quantified health providers' preferences for policy options. Methods: Qualitative interviews with government providers, health managers, and policy stakeholders were used to determine perspectives on dual practice policy options. Government doctors and nurses completed a self-administered questionnaire, including a stated preferences elicitation approach (best-worst profile scaling) on policy options. Respondents were required to select the most and least important policy options in a series of nine choice tasks. Findings: Most respondents suggested that a formal government policy on dual practice, including provisions for various types of health providers, would be useful. Based on the qualitative work, four categories of policy elements emerged: salary, work structure, benefits, and dual practice. Each of these contained three policy options. Based on the best-worst scaling questions, salary and work structure - specifically a 100% increase in government salaries and supportive supervision - had the highest relative importance among attributes. Policy options related to dual practice, such as declaring one's dual practice, were ranked least important. Discussion: Understanding provider preferences related to dual practice and other coping strategies is essential for recognizing providers as people. The importance that providers placed on work structure policy options, and particularly supportive supervision, point to linkages and opportunities between dual practice and broader public sector management improvements. Initial analyses suggest that differences in policy preferences might exist among provider types.
Health worker migration from Jamaica: causes, consequences and responses.

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ABSTRACT

Background: An adequate health workforce is essential to an effective health care system. The health workforces in many countries are subject to high levels of migration of highly trained health personnel. The aim of this study is to better understand the drivers of migration, its consequences, and the various strategies countries have employed to mitigate negative impacts of it. The study was conducted in four countries - Jamaica, India, the Philippines, and South Africa - which have historically been 'sources' of health workers migrating to other countries. This paper presents findings from Jamaica.

Methods: Data were collected using surveys of several categories of Jamaica's health workers including generalist and specialist physicians, nurses, midwives, and dental auxiliaries, as well as structured interviews with key informants representing government ministries, members of professional associations, regional health authorities, health care facilities and educational institutions. Quantitative data were analyzed with Microsoft Excel and SAS version 9. Qualitative data were analyzed using NVivo 10. Multiple stakeholder engagement workshops were held across Jamaica to share and validate the study findings and discuss implications for the country.

Results: Migration of health workers from Jamaica continues to be prevalent. Its causes are numerous, long-standing, and systemic, and are largely based around differences in living and working conditions between Jamaica and 'destination' countries. There is minimal formal tracking of health worker migration from Jamaica, making scientific analysis of its consequences difficult. Although there is evidence of numerous national and international efforts to manage and mitigate the negative impacts of migration, there is little evidence of the implementation or effectiveness of such efforts.

Conclusion: Better managing the migration of Jamaica's health workers requires collaboration from stakeholders across multiple sectors. Participating stakeholders identified a wide range of potential strategies to better manage migration of Jamaica's health workers, which will be discussed during the session.
Determinants of job satisfaction among primary health care workers in selected States in Nigeria

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ABSTRACT

Significance To demonstrate the need for improvement of health-worker job satisfaction to maximize sparse human resources for health (HRH) in underserved areas. In Nigeria, acute shortages in trained HRH are a major contributor to the less-than-desirable quality of care and high MMR of 545 deaths per 100,000 live births (DHS, 2008). Innovative approaches are required to ensure that productivity is maximized among the sparse available skilled health personnel to improve outcomes. Partnership for Transforming Health Systems 2 (2008-2014) project has been supporting the Government of Nigeria to achieve the MDGs by working in underserved areas. This study evaluated the association of work incentives with primary health care (PHC) worker job satisfaction levels. A descriptive cross-sectional Health Provider Survey was conducted in 5 Nigerian states from August–September 2012 to assess job satisfaction levels and their knowledge and practice in key MNCH areas. Data collection involved administration of a structured questionnaire to 889 Nurses/Midwives and Community Health Extension Workers in 594 PHC facilities. Logistic regression was used to evaluate the association between incentives and job satisfaction using STATA version 12.1. Preliminary results show that amongst the 889 respondents, 79.2% reported being happy with their job. 83.2% of health workers reported receiving at least one job-related incentive, including increased salaries/allowances (71.3%), training and learning opportunities (32.5%), free accommodation (12%) and free transportation/car loans (6.1%). Logistic regression showed that those receiving at least one job-related incentive were significantly more likely to be happy with their job (unadjusted OR; 1.51, 95% CI; 1.00-2.26, p=.048). Further analysis will explore other confounding factors including cadre, length of service/experience, on-the-job trainings and other incentives. These preliminary results already indicate that provision of simple and attainable job-related incentives can significantly improve job satisfaction in underserved settings where there is an increased need for maximum health worker productivity.
Health labor markets in Africa: money chasing health workers?

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ABSTRACT

Introduction Rapid economic growth and a demographic bulge have driven the demand for health workers in Africa. Yet, human resources policies have remained rigid. Africa still has the lowest density and production of health workers worldwide. A recent book, 'The Labor Market for Health Workers in Africa: A New Look at the Crisis', produced by the World Bank, the African Development Bank, and the University of California-Berkeley, analyses the health workers crisis in Africa from a labor economics perspective. This paper summarizes the book’s findings, drawn from available data and research. Findings Shortage is observed in many, but not all, African countries. True shortage where ‘money chases health workers’ drives fierce competition between government, donors and the private sector for health workers including poaching, wage inflation, moonlighting and unfilled vacancies. Wage bill ceilings are generally less a binding constraint than insufficient funds for pre-service training. The health workers deficiency in Africa remains a rural problem, yet few countries have an effective rural pipeline. Little attention has also been given to the emergence of the private sector. About half of the health expenditures in Africa are private, and the number of private nursing schools is rising rapidly. Performance of health workers is also low. In Tanzania, the average clinician doing about 40 percent of what he should do for patients. Yet success is possible. Ethiopia has trained more than 30,000 health extension workers for rural areas. Ghana increased remuneration of doctors and nurses. In Rwanda, health workers remuneration now depends on performance contracts between the government and autonomous facilities. Conclusion The African health labor market operates in a diverse mix of institutional models. Decision-makers in African countries should invest in research to better understand the dynamics of the market for health labor. Only then can countries respond effectively to the human resource crisis.
A system innovation perspective into how a promising malaria control intervention evolves from an interaction between technical, social and ecological phenomena, Rusinga Island, Kenya, 2012-2013

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ABSTRACT

Background: There has been increasing effort in recent years to incorporate user needs in technology design and re-design. This intervention employed a bottom-up approach that engaged end users from the outset. Bottom-up approaches have the potential to bolster novel interventions and move them towards adaptive and evidence-based strategies. The present study concerns an innovative use of solar powered mosquito trapping systems to control malaria in western Kenya. Methods: During the pre-intervention year, we examined the design, re-design and implementation of a novel technology to generate lessons for malaria elimination on Rusinga Island. Initial ideas about many technological necessities were evaluated and re-designed following feedback from various sources including technical and social research as well as broader interactions with the social and bio-physical environment. We documented the interlocking of the multiple processes and activities that took place through process observation and documentation and document reviews. We analyzed the data within the conceptual framework of system innovation by identifying mutual shaping between technical, social and bio-physical/ecological factors. Results: Our findings illustrate how various project stakeholders including project staff, collaborators, donor, and community members simultaneously pursued interdependent technological transformations and social interests. In the ongoing process, we observed how partial outcomes in the technological domain influenced social events at a later phase and vice versa, as well as how biophysical and ecological conditions also played a role. Thus, in order to effectively combat malaria, the new technology needs to become adapted and linked to both a dynamic social and relevant biophysical/ecological environment. Conclusions: Looking at intervention projects as niches that may evolve towards system innovation helps to reveal interrelations between the various technical, social and biophysical/ecological aspects. To do this requires a different role for research and different perspective on innovation where innovation is more than the technical aspects.
Inter-disciplinary research for people-centered health systems: how to overcome the challenges in practice?

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ABSTRACT

Background People-centred health systems are about health, social justice and human rights, health systems and service delivery. Therefore, research requires a holistic analytical approach and is 'deliberately interdisciplinary' and it applies a range of methodological approaches' (Background note Third Symposium). Despite the recognition of its importance, researchers and practitioners who want to engage in interdisciplinary research are confronted with a number of challenges. How easy is it to engage in research across experience and disciplinary boundaries? How to build on knowledge from different disciplines in order to generate relevant insights for the development of people-centred health systems? Information on purpose

The aim of this presentation is to critically assess the promises of inter-disciplinary research for people-centred health systems based on experiences with a research project on social accountability and responsiveness. In that project, researchers combine knowledge and data from, for example, bio-medical, human rights-based, public health and empowerment perspectives and approaches. They involve different paradigms, focus areas and research methods and the researchers wonder to what extent joint conclusions and policy advice can be drawn from this broad range of knowledge sources. Researchers and practitioners with similar experiences and dilemmas are the targeted audience for this presentation and discussion.

Focus/content The poster or presentation will visualize the process of a systematic review conducted by the presenters, in this case according to the steps of a realist review. For each stage in the process the successes and obstacles for inter-disciplinarity will be exposed. The presenters will further stimulate a discussion with participants on how to address this central issue in research for people-centred health systems. They will share their thoughts on the potential of a realist approach to overcoming inter-disciplinary boundaries because of its allegedly neutral and inclusive character (theory building with inputs from different disciplines, method-neutral, including academic and non-academic literature and knowledge).
Is the concept of absorption capacity misleading us?
The case of the Mozambican health sector

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ABSTRACT

Purpose Large inflows of external resources have spawned a discussion about the so-called absorptive capacity of developing countries and their institutions. Our aim is to advance the concept of absorption capacity by taking a people-centred approach that acknowledges that health systems are shaped by how leaders and managers exercise authority. We use the case of the Mozambican health sector to investigate whether thinking in terms of absorption capacity neglects important aspects of the funding relationship. A proposed alternative way of conceptualising the funding relationship moves the focus away from absorption towards the more holistic notion of the 'quality of a funding relationship'. This altered perspective entails shifting attention towards those individuals who conceive and administer a funding relationship. Secondly, it transfers some of the responsibility for the effectiveness of aid towards the 'donor' and thus creates a more equitable share of responsibility for the success of funding. Methods We combine conceptual and empirical research to analyse the case of the Mozambican health sector. We use quantitative data from the 'Inquerito dos fundos externos' which contains information on planned and actual disbursements. Qualitative data from interviews with key stakeholders are analysed to determine where differences between plans and actual values stem from. In the conceptual part we break down the concept of 'absorption capacity' to uncover the implicit assumptions that it entails. We use the empirically gained insights to advance the existing concept towards a framework that takes into account the roles of individuals involved in funding relationships that are embedded in a larger system. Significance for the selected field-building dimension Advancing the absorption capacity paradigm towards a focus on relationships between individuals involved in the funding relationship can increase the effectiveness of external funding of health systems. Target audience Administrators, planners on both sides of the funding-relationship, advocates and researchers.
Strengthening ART provision to increase patients' access to care: number of avertable deaths in four African countries

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ABSTRACT

Background Inefficiency in service provision is a major cause for unmet access to antiretroviral therapy. When services are provided inefficiently, scarce resources that could be used to treat additional patients are wasted. While studies on inefficiency in African countries exist, no effort has been made to link the level of inefficiency to the potential increases in ART coverage. Methods We use 2810 facility-year observations from Ghana, Zambia, Uganda and Kenya to estimate the inefficiency of health care service provision. We propose an innovative approach to adjust for technology heterogeneity across facilities and make outputs comparable. Efficiency scores are derived from advanced DEA models. Iterative super-efficiency models are used to remove outliers from the sample. An easily-replicable technique to restrict input- and output weights prevents inflated efficiency scores of specialized facilities. The number of patients expected in a fully-efficient counterfactual scenario is compared to the observed number of ART patients. This difference informs us about the potential increase in ART coverage expansion. These results are extrapolated to the national levels using a version of UNAIDS Spectrum model. We included demographic inputs, estimates of the prevalence and incidence of HIV and ART coverage rates and other HIV-related inputs. Results We find low levels of efficiency in the provision of ART care; 33% on average. The total number of avertable deaths is 46,827 for Ghana, 290,245 for Kenya, 112,450 for Uganda and 145,222 for Zambia. These estimates abstract from demand-side constraints. Discussion This analysis suggests that important returns in terms of lives saved can be achieved by strengthening the provision of ART services to minimize the amount of wasted resources. Efficient service provision not only increases equity in access, but also equity in resource allocation without requiring additional resources. The developed DEA-based framework can assist MoH in the measurement of efficiency.
Evaluation of the health-related quality of life and the influencing factors of residents in rural China

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ABSTRACT

Evaluation of the Health-related Quality of life and the influencing factors of residents in rural China Jian Wang, Li Zhang Center for Health management and Policy, Shandong University; Key lab for Health Economics and Policy Research, NHFPC With the development of economy and the society, people's health is obviously improved in China. The average of life expectancy is extending. But we know a little on the quality of life (QOL) of rural residents. Objective: to understand the status of the rural residents health related QOL and its influencing factors. Methods: according to stratified cluster random sampling, 5 townships and 17 villages were investigated in 2009. The QOL information of 11542 interviewees more than 14 years old was collected by ED-5D scale. Chi-Squared test and logistic regression equation were adopted to compare and analyze the influencing factors of QOL. Main results: 1) Average self-reported health score was 82.57. Among five dimensions of QOL 'pain/discomfort' was the most serious, 20.3% of people felt paint/discomfort. Next was 'anxious/depression', 6.4%. 2) Comparing analysis disclosed that as aging, the QOL decreased; Men's QOL was better than female's; income and education were positively related to QOL; Divorced or widowed people had poorer QOL; free-smoking People faced less health problems; people sleeping for seven to eight hours each day had less health problems. 3) By Logistic regression analysis 7 variables were found statistically significant influencing self-reported health score or 5 dimensions of QOL, including age, educational, income, smoking, sleeping time, chronic disease, and whether sick or not within recent 2 weeks. Conclusion: The main problems on QOL were 'pain/discomfort' and 'anxious/depression'. Improving the education level, establishing healthy behavior, reducing income gap can increase the QOL of rural residents. Key words: rural residents; health related QOL; EQ-5D
Operationalizing a systems thinking approach: Using group model building to develop health systems interventions

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ABSTRACT

This presentation illustrates the use of group model building (GMB) as a process to convene stakeholders in the identification of the systems nature of challenges. There is increasing recognition that health systems challenges are inherently complex, and that planning interventions that respond to the needs of the population should be informed by the interaction of factors across a range of levels. Analysing such complex interactions in a manner that is accessible to policy-makers and practitioners is demanding. Graphic systems dynamics tools offer a potentially powerful method for supporting stakeholders in the analysis of this complexity. We have adopted these tools for work with stakeholders in a range of settings, using an approach focused on a structured process of GMB. We describe two contexts where this approach has been adopted. GMB has been a core methodology within a southern Africa region health systems strengthening initiative where Ministry of Health staff and CDC colleagues examine opportunities for HIV service scale-up to support broader health systems strengthening goals. Systems maps and intervention strategies identified by country teams through supported GMB are shown. GMB has also been the central methodology in our work on systems performance in contexts of adversity. We describe conducting a GMB exercise with staff from an organization providing technical support to the Cote d'Ivoire Ministry of Health during the 2010 civil disturbance. The process involved a scoping phase, where themes and variables related to the problem were identified through key informant interviews, refined through an iterative process of reflexive enquiry, and a preliminary 'seed model' developed. Model building itself involved working with a group of stakeholders prompted by the seed model - to identify underlying structures and collective mental models of the problem. The resulting systems model used to consider the potential impact of alternative scenarios of intervention is illustrated.
Design and base-line evaluation of financial incentives to increase effective coverage of priority health interventions. Recent experience of Seguro popular in Hidalgo, Mexico.

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ABSTRACT

Purpose. To present the design, implementation and evaluation challenges of a ground-braking experiment with results-based financing (RBF). Content. Mexico's Seguro Popular has contributed in the last 10 years towards universal financial risk protection. However, chronic disease coverage is still low, with only 26% and 30% of adult men and women, respectively, accessing preventive care. Seguro Popular in the state of Hidalgo, with 1.7 million affiliates, introduced a results-based, financial incentive scheme to improve performance of key outputs and outcomes. Twenty primary care and five hospital care indicators were chose to cover diabetes and cardiovascular prevention and control, prenatal care and delivery, breast cancer screening, oral health, family planning, surgical efficiency, access to services and interpersonal quality. Indicator survey data was used to set baselines. Expert panel data on provider infrastructure capacity and outcome control were used to set short-term objectives aiming towards national goals. Burden of disease, intervention costs and expert priorities were used to establish a standardized performance point system across indicators as to facilitate monitoring and compare provider performance. The size and socioeconomic level of coverage targets were used to set the performance point cash value for each provider. A differentiated performance point payment scale was set with discounts and incremental bonuses. The size of the incentive fund was established at 10% of the providers’ budget. The impact of performance incentives on activity and health care costs was estimated to ensure viability. A case-control evaluation base-line and an implementation research protocol were established. Significance. Evaluation of the RBF scheme promises to speed-up the introduction of financial incentive schemes for Seguro Popular at the national level and to provide much needed experience for other performance incentive schemes around the world. Target Audience. Decision makers, consultants and researchers involved in the design of results-based financing innovations.
Strengthening public health workforce of the Philippines through improved public health education

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ABSTRACT

Background: A number of educational institutions have been offering Master of Public Health (MPH) programs in the Philippines. Though there is an accreditation scheme for these programs, there are calls to look at their overall impact and see how they address the health needs of the country. This study is part of a bigger program to evaluate public health education in the Philippines and look at its relevance in a wider perspective.

Methods: A survey of educational institutions offering formal public health education and related fields has been conducted to understand the contribution of the programs to the graduate, the community and the wider society. Part of the study is to look at the different competencies of the program based on the curriculum and from the standpoint of the faculty and graduates. A combination of methods was used including in-depth interviews and document analysis.

Results: There has been a rise in MPH programs mostly by schools of medicine. Most of the students studying are medical doctors and other health practitioners working for the government and public health organizations. The enforcement by the government to have a master degree for purposes of work promotion increased the enrolment. There are variations in the curriculum of the programs offered and there is no emphasis on these programs on the competency development of the workforce. The quality of programs is not systematically evaluated and is not developed based on actual competencies needed by the country. Teaching faculty are not subject specialists. Research is not a major focus of the program and institutions.

Conclusion: Institutions offering MPH should have a clear framework on how the program link with the health and development challenges of the country by focusing on appropriate competencies. Public health education has a lot of potentials to improve the health human resources.
Workforce planning for universalisation: The case of free GP care in Ireland

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ABSTRACT

Moving to Universal Health Care typically involves the removal of price barriers with resulting increases in demand for health care. Yet the supply side must also be able to respond. This presentation reviews the use of workforce planning to support the free GP policy in Ireland announced in 2011. The presentation forecasts the increase in demand, as well as identifying and evaluating human resource strategies that can be employed to cope. It also assesses the utility of workforce planning. The presentation draws on a workforce planning model developed for the Irish government. Data collected include the utilisation of GP care by different population groups, the likely growth in population by age and gender, projected growth in chronic disease prevalence, the current availability of GPs, practice nurses and pharmacists and the demographics of workforce cadres alongside migration patterns. Estimates of the elasticity of demand are calculated from existing household datasets. The results show that if the policy is implemented, there will be a gap between demand and supply of 2.5 million visits by 2015. This equates to an increase of 17% on 2010 utilisation levels or around 400 extra GP WTEs. Although the free GP care policy is the largest driver of demand, the ageing population with increased chronic disease accounts for 40% of the increase. No one strategy will bridge this gap but the most effective are increasing GP efficiency and using pharmacists to deliver primary care. The increased use of practice nurses is also beneficial. Combining these strategies together will allow the gap to be bridged. The presentation concludes by considering the utility of workforce planning. It is useful in allowing modelling of different policy scenarios and responses but it fails to provide detailed design of strategic responses and is reliant on good data and realistic assumptions.
Assessing changes in health worker motivation and job satisfaction: Building multiple assessment methodologies into program design

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ABSTRACT

Background: Evaluations of programs often take too long because they are left until the end of the program; and results cannot be fed back to make ongoing program improvements. The Care Community Hub (CCH) pilot in Ghana, part of the Innovations for MNCH initiative where implementation is based on the results of the design thinking process, follows an 18 month rapid evaluation model equipping nurses with a mobile health platform to influence motivation. Evaluation proceeds in tandem with program development and implementation activities, utilizing data from Community Health Nurses (CHNs) and Officers (CHOs) to feed back into the intervention design. Methods: 240 CHNs and CHO\textsuperscript{s} from two regions in Ghana are involved in the study. For a user-centered mobile health platform, a mix of methodologies built into the program gathers information on nurse motivation and the CCH platform. For the baseline assessment, a short survey will be implemented during training coupled with 75 in-depth interviews with CHNs/CHO\textsuperscript{s} and supervisors. Quarterly assessments will be conducted with a smaller group of selected program staff, health workers and supervisors. Mobile usage indicators will be collected quarterly to supplement the qualitative data. Discussion: Conducting this evaluation design in tandem with program development and implementation allows for frequent course correction using data from various sources, particularly nurses using the mobile platform. It enables more in-depth to inform programs through the use of multiple data collection methods. In addition, it is also a logistic and cost-saving. Short surveys built into program activities and usage indicators collected via the platform surveys are inexpensive and easy ways to refine a user-centered platform. Conclusion: This study will demonstrate how multi-method evaluations that use user data may increase the uptake of a mobile health platform targeting health worker motivation. We provide evidence for best practices in evaluating mobile health applications.
Public Private Partnerships (PPP) for improving maternal and neonatal health service delivery

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ABSTRACT

Background: There is an increased interest in PPPs for improving Maternal and Newborn Health (MNH) in Low and Middle Income Countries (LMICs). However, there is a lack of collated evidence on PPP performance and relative effectiveness of the various competing PPP models. Methods: We systematically reviewed evidence from LMICs on the effectiveness of PPPs for MNH and the comparative edge of different PPP models. Results: Evidence from 27 studies suggested an overall increase in the utilization of maternal health services including improved antenatal care (ANC), C-sections and institutional delivery with limited data on postnatal care (PNC) and maternal mortality. Voucher schemes improved both ANC and PNC utilization as well as access to institutional deliveries with little impact on emergency care. Evidence from maternal conditional cash transfers indicated increase in institutional deliveries and reduced maternal mortality while contracting out of services had a positive impact on delivery and ANC. There is little evidence of increased access to emergency and postnatal care with contracting out and contradictory results on immunization. National and community based health insurance resulted in significant improvement in facility based births and C-Section, but with little evidence of translation into promotive pregnancy care. User fee exemption initiatives have conclusively resulted in increasing institutional deliveries. Discussion: Most PPPs interventions inadequately cover the full range of maternal, child and EmONC services; there is scant attention to neonatal care services and they are also affected by issues concerning payment modalities, state ownership and health system support. Administrative costs of PPPs are not known and are expected to scale up. Conclusions/Recommendations: Existing evidence suggests the potential benefits of PPPs, however future PPPs should be better designed with standardized evaluations for a range of MNH services. Programs should also focus on the contextual factors for future sustainability and program replication.
Building a routine and responsive health workforce planning system: What can we learn from Kenya?

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ABSTRACT

Purpose: We present findings and lessons learned from a first-phase assessment of selected human resources for health (HRH) cadres in Kenya. The work was conducted by the Ministry of Health (MoH) with support from the USAID-funded, IntraHealth International-led FUNZOKenya project. We share technical recommendations for building a workforce planning system that is responsive to planners and helps create an enabling environment for health workers. Focus: The review and analysis were based on data sources identified in discussions with the MoH, regulatory bodies, and health professional associations. We also collected primary data to address major gaps in information on the private sector. Assessment findings have provided insights on the distribution of HRH between the public and private sectors, as well as health workforce growth and attrition patterns. Findings revealed that: (1) it is difficult to monitor imbalances in the health workforce without clearly defined benchmarks or indicators; (2) the private sector health workforce has not been systematically included in national planning efforts; (3) HRH information in Kenya is fragmented; and (4) a culture of information sharing and use has not yet been established. Significance: Assessment findings are paving the way for development of an information dashboard system for monitoring HRH indicators at timely intervals. The real-time, online HRH information dashboard system, which will draw from various data sources including the IntraHealth iHRIS platform, can support evidence-based recruitment, hiring, and training of health workers. In Kenya, this is happening in the midst of health system decentralization and major MoH restructuring, which has required careful navigation and attention to the different views and priorities of key stakeholders. Audience: Lessons learned in Kenya can inform practitioners in other countries exploring similar information dashboard systems. Our findings are particularly relevant for researchers, policy-makers, and planners involved in developing health workforce planning systems in low- and middle-income countries.
Costed implementation plans for family planning: 10 steps to developing actionable strategies

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ABSTRACT

Costed Implementation Plans (CIPs) for family planning are concrete, detailed plans for achieving the goals of a national family planning program over a set number of years. A CIP details the program activities necessary to meet stated goals and the costs associated with those activities, thereby providing clear program-level information on the resources a country must raise both domestically and from donors to achieve their goals. The CIP addresses and budgets for all components of a family planning program demand, service delivery and access, procurement and supply chain, policy and enabling environment, financing, supervision, and monitoring and evaluation. The USAID-funded Health Policy Project's 10-step approach creates a CIP aligned with ongoing government planning and coordination efforts. By including processes to ensure inclusion of often-marginalized populations and civil society groups, this approach ensures that the national CIP is collaborative, country-owned, and country-driven from inception. The 10-step approach also utilizes custom tools to develop detailed cost estimates, to identify financing gaps, and to estimate the demographic, health, and economic impacts of successful CIP implementation (e.g., number of women's and children's lives saved, healthcare costs saved, etc.). The CIP process culminates in a consensus-driven strategy, as well as a detailed activity roadmap and budget to make the strategy actionable. The 10-step approach results in strategies that promote people-centered health systems that improve healthcare outcomes through respecting rights, addressing social exclusion and inequities (with a focus on gender, adolescents, and people living in rural and underserved areas). This presentation is relevant to a wide cross-section of the Symposium's diverse target audiences, particularly policy-makers, managers, and civil society participants, who would benefit from learning about the experiences of various countries in developing costed health strategies that are participatory and inclusive.
Indicators for tracking health research capacity strengthening in lower and middle income countries: a qualitative synthesis to identify opportunities for improvement

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ABSTRACT

Background A basis for generating systematic knowledge on health systems research capacity strengthening (RCS) is agreement on valid measures or indicators. We sought to catalogue the types of indicators being used to evaluate health RCS and to assess potential gaps in quality, coverage, and equity considerations.

Methods We purposively selected twelve evaluations to maximize diversity in RCS, funders, countries and approaches to evaluation. We explored the quality of the indicators and extracted them into a matrix across individual, institutional and system levels, based on a matrix in the ESSENCE Planning, Monitoring and Evaluation framework. We synthesized across potential impact pathways (activities to outputs to outcomes) and iteratively checked our findings with key health RCS evaluation stakeholders. 

Results Evaluations varied remarkably in the strengths of their evaluation designs. Validity of indicators and potential biases were documented in a minority of evaluations. Indicators were primarily of activities, outputs or outcomes, with little on their inter-relationships. Individual level indicators tended to be more quantitative, comparable and attentive to equity considerations. Institutional and system level indicators were extremely diverse. Improvements in people-centred health systems were infrequent outcomes of interest, though particular examples of shifts in health policies and programs were cited in some evaluations. Linkage of activities through outputs to outcomes and use of an explicit theory of change were limited among the evaluations. However, we were able to construct potential pathways of change based on indicators within each level.

Conclusions Opportunities for improving RCS evaluations include work on indicator measurement properties, the refinement of indicators on relationships with knowledge users, and inclusion of indicators of impacts on people centred health systems. Greater attention to evaluation design, prospective indicator measurement, and systematic linkage of indicators, in keeping with theories of change, could provide more robust evidence on RCS effectiveness.
Developing a tool to assess capacity of Ministries of Health to demand and use research evidence to improve decision-making

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ABSTRACT

Purpose: To develop an instrument to assess the demand and use of research evidence by Ministries of Health (MoHs) in low- and middle-income countries (LMICs) at three levels: individual, organizational and systems or across organizations. Focus/content: Based on a conceptual framework developed from previous research and pre-testing, the instrument is comprised of three sections that correspond to three levels of capacity. The instrument was administered in-person with 25-30 MoH officials in eleven countries globally that represent a variety of income levels, WHO regions, population, and type of health system. Reliability testing was conducted, including test-retest and internal consistency statistics. Exploratory factor analysis was employed to explore the latent structure of the instrument to reflect demand and use of research evidence by MoHs. Analysis is ongoing and will be finalized by July 2014. The results of reliability and validity testing will be used to finalize the instrument for implementation. Significance: A great deal has been learned about how to improve the communication of research findings to decision-makers. This project focuses on the perspective of decision-makers: the potential users of research. Whereas improving the supply of research evidence and its dissemination are important tasks, understanding the needs of the individuals on the demand side is also crucial. Earlier instruments assessing the use of research evidence have considerable limitations, especially for LMIC settings. The instrument validated through this pilot is focused on a user's perspective and in a language with which they relate. The goal is for MoH officials to use the instrument to evaluate their own demand and use research evidence in decision-making and identify ways to improve in the future, with the overarching objective of improving MoH capacity, service delivery and quality.
Reasons for discontinued clinic attendance: perspectives from ART patients in Cote d'Ivoire

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ABSTRACT

Background Interventions which seek to address the underlying causes of treatment discontinuation among patients living with HIV/AIDS on antiretroviral therapy (ART) often fail to use a patient-centered approach. The objective of this analysis was to explore reasons for discontinuing clinic attendance from the perspectives of ART patients in order to inform the development of patient-centered programs to promote retention in Cote d'Ivoire. Methods A total of 7070 patients on ART who had discontinued clinic attendance for three months or more were identified from 42 facilities. Those for whom contact information was available (3037 or 57%), were traced by community health workers, and their real outcomes assessed. Qualitative data were collected through interviews on factors that influenced the discontinuation of clinic attendance. In-depth interviews were also conducted with a subsample of 23 patients who had discontinued treatment. Results Of the 3037 patients traced, 22% had self-transferred to other facilities and 25% had discontinued treatment. Reasons for self-transferring included: moving/traveling, fear of being recognized, and being treated poorly by facility staff. Traveling or moving (28%) and side effects (15%) were the reasons most commonly cited by respondents for discontinuing treatment. In addition, long wait times and dissatisfaction with the way they were treated by facility staff were also cited as reasons for discontinuing treatment. In-depth interviews revealed that reasons for treatment discontinuation included: social/professional commitments, fear of being recognized, long wait times, poor relationships with providers, and perceiving treatment as ineffective. Conclusion A significant proportion of patients on ART who discontinue clinic attendance were receiving treatment from other facilities, often because they were dissatisfied with the care received. A patient-centered approach addressing respectful care, long wait times, fear of being recognized, and accommodating travel may promote retention among ART patients in Cote d'Ivoire.
Moving parts: randomized evaluation of a novel approach to improve transportation for healthcare providers in Zambia

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ABSTRACT

Background: The aim of Riders for Health is to remove bottlenecks to healthcare delivery that result from unreliable motorized transport. Transport is central for delivery of effective and equitable healthcare to rural populations in Africa, yet despite this potential role, the impact of transport improvements has not been studied. Methods: Eight districts in Zambia's Southern Province were randomly assigned to the Riders intervention (new and maintained motorcycles), or usual maintenance. Using weekly surveys of health workers (Environmental Health Technicians, EHTs) and GPS trackers, we measured motorcycle condition (uptime and utilization), EHT productivity, and healthcare delivery to remote and underserved communities. Results: 5-month baseline data collection was completed in 2/2012, and two years of intervention will be completed in 3/2014. We tracked 169 motorcycles and 128 EHTs. A third of motorcycles had GPS trackers. The following results are preliminary through 20 (out of 24) months of the intervention. During the baseline period, motorcycles were up and running with fuel 1.7 days/week and 2.1 days/week in the control and experimental districts, respectively (p=NS). During the intervention, Riders motorcycles were running 5.4 days/week on average (p<0.05 for difference). Utilization of running motorcycles did not change in the intervention districts (4.3 days/week in the baseline and 4.6 during the trial), and increased from a low baseline in the controls (from 1.8 to 3.9 days/week, p=NS). Riders also increased EHT productivity: the number of monthly outreach trips increased from 3.7 to 6.5 per EHT in intervention districts and remained unchanged elsewhere (p<0.05 for difference). Moreover, a greater number of outreach visits were conducted at sites farther afield from the EHTs' health facility base. Conclusion: At baseline, transport is poorly maintained and underutilized for healthcare provision in Zambia's Southern Province. Maintenance interventions can improve motorcycle fleet condition, health worker productivity, and healthcare delivery to remote communities.
Selecting gold-standard population survey samples cheaper, faster, and easier for health system evaluations using gridded population data and satellite imagery

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ABSTRACT

Purpose: Population health data are used to evaluate impacts of public health interventions. Household surveys such as the Demographic and Health Surveys (DHS) provide sub-nationally representative data, typically using two-stage cluster samples of approximately 10,000 households. DHS GPS coordinates of primary sampling units (PSU-village/neighborhood) allow data to be re-aggregated. For example, a 2006 intervention implemented in 15 sectors of Rwanda can be evaluated with difference-in-differences analysis using 2005 and 2010 DHSs, grouping data from intervention and non-intervention areas. Governments and organizations involved with large-scale interventions may wish to collect gold-standard DHS-style survey data, but find that the creation of a first-stage sampling frame from census data, and a second-stage sampling frame from hand-drawn community maps are prohibitively costly and time-intensive. Relatedly, small area estimation of population health outcomes using DHS data result in large spatial errors because DHS data are only representative of the population; not of space. Focus/content: We propose a method to design gold-standard population surveys using free, publicly available datasets. This saves considerable time and money, and optionally allows for samples that are representative of both population and space. We wrote an R algorithm that allows users to specify the geographic boundaries of strata, parameters of the two-stage cluster sample, and whether to oversample in urban/rural areas. The algorithm outputs a spatial dataset (shapefile) of PSU boundaries, and includes information to calculate sampling weights. Where Google Earth or other satellite imagery are available, the PSU boundaries allow dwellings to be listed and sampled easily before starting field work. We evaluate the performance of this method against a DHS sample. Significance: Gridded population sampling empowers governments and organizations to conduct robust evaluations of health systems and interventions. Other applications include the study of informally-settled populations, populations in conflict zones, and human-environment interactions. Target audience: Evaluators of large-scale interventions
Successfully connecting NGO practice and Health System Research - get evidence into NGO practice & NGO practice into research

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ABSTRACT

Background: Good people-centred health systems build on researchers, policy-makers and implementers creating, sharing and applying knowledge. NGOs translate people’s needs into action. Researchers generate systematic knowledge for evidence-based decisions and actions. Methodology: The aim of the study was to develop a framework on how to get evidence into NGO practice and for supporting researchers to get NGO practice into their research. Enablers, barriers, and supportive tools are identified for NGOs to integrate more evidence into their work; and for NGO-Research Collaborations. A literature review, an online questionnaire collected information from 30 NGOs, face to face interviews and two workshops involving 18 NGOs and 8 Researchers were conducted. Case studies showing good practices of NGOs integrating evidence into their work and of NGO-Research collaborations were identified. Results & Conclusion: The findings highlight challenges for NGOs to integrate health systems research in their work, and difficulties with the uptake of research findings into practical NGO work. Especially larger NGOs have increased investments in research and show institutional buy-in. NGOs and Researchers alike see collaborations as beneficial for both. However, they are challenged by different time lines, incentive structures, and working cultures. For successful collaborations, sufficient time has to be invested to build a relationship that is based on trust, respect, transparency and equity. Available tools and resources have been compiled in a ‘Toolbox’ for NGOs and Researchers to facilitate collaboration, as well as for NGOs to integrate evidence into practice. Tools alone will however not be sufficient to support the process - an enabling environment is required within NGOs (‘doers' becoming ‘doer-thinkers’), Research Communities (‘thinkers' becoming ‘thinker-doers’) as well as Funding Agencies (‘funders of results' becoming 'funders of processes, results and research uptake’). Only the collective capacity of all stakeholders will enable creating, sharing and applying knowledge to establish people-centred health systems.
Health system strengthening through a systematic and innovative approach in Bangladesh

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ABSTRACT

Health System strengthening through a Systematic and Innovative Approach in Bangladesh Purpose This is a project funded by WHO and implemented by DGHS in Bangladesh to strengthen the Health system (HS) with a hypothesis, major improvement of health system performance is possible within existing resources by a systematic approach under good governance, motivation, inspiration and stimulation. We also tried to bring the entire stakeholders working in health sector of Bangladesh in a platform to vitalize HS. Focus/content Strengthen the health system and enlist all existing activities and programs with respect to six building blocks of HS. Consultative meetings organized with central level stakeholders to develop the data collection tools regarding baseline status of some selected indicators on HS from upazila, district and tertiary hospitals and survey was conducted through online reporting system to know the baseline status. Then it was organized workshops with heads of the facilities for identification of intervention areas and development of HSS improvement plans. Development of guidelines and tools for off line and on-line monitoring of implementation was done to have field level assessment of improvement by divisions and HSS Cell. Finally best performing health Facilities in different categories were identified for Health-Minister’s Championship Awards. Significance for the selected field This project created enormous enthusiasm among the head of the facilities and now they are highly motivated to strengthen their institutes. Those who have received awards they promised to keep their facilities sustainable well functioning and other promises to improve. This project may be the best Model for other LMICs. Audience This innovative approach might be used by the other health sector leaders and all stakeholders who are involved in the development of HS action plan in broad and abroad. Key Words: Health System Strengthening, Innovative Approach Correspondence: Md. Mofijul Islam Bulbul
Empowering children in health care decisions; end-user participation in information development

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ABSTRACT

Background: Various international guidelines stress the importance to involve children in decision-making on medical treatments and research participation. However, medical information material for children is often complicated and hard to understand. In order to empower children in health care decisions, information material should target them as health care users and address their information needs and preferences. This paper reports on a participatory approach which aimed to develop information about research participation for children. Methods: The new material consists of a comic strip explaining general key concepts of scientific research and a study-specific consent form. A draft of the comic strip was tested among 143 school children (age 10-14) of different educational levels. Children provided feedback for further development in surveys and qualitative interviews. Next, the combined product was discussed in 2 focus groups with children and 2 focus groups with research nurses. Subsequently, the material was presented to 80 children (8-17) in a clinical study and their parents. Findings: School children provided feedback on the material and insights in information needs, which resulted in revision of the material. After revision, understanding of eight key research concepts ranged between 65 and 99%, with an average of 83%. Research nurses indicated the new material would facilitate their role as a patient educator and delivered recommendations for optimal implementation in the clinic. Children of a clinical study and their parents contributed to enhancing the product to support the family conversation. Discussion: In order to address health information needs of children, participation formed the base in developing new information material. All end-users were involved in various developmental stages to ensure optimal understanding, user-friendliness and implementation in the clinic. By not only addressing medical needs, but also information needs and preferences, people-centered health systems can empower vulnerable health care users and strengthen health care delivery.
Open contests spurring innovation in HIV testing programs: A pilot program in China to increase HIV test uptake

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ABSTRACT

Purpose: Designing innovative HIV testing and linkage interventions is challenging. Groupthink, defined as the inclination to produce similar concepts when insulated from outside influences, inhibits innovation and leads to homogenous campaigns with minimal input from key populations. The conventional approach to designing and implementing HIV testing interventions can be enhanced through crowdsourcing. Crowdsourcing is the process of taking a task performed by an individual and outsourcing it to a large group in the form of a contest or open call, often publicized via the Internet. Open contests tap into the diverse wisdom of the crowds and at the same time increase community ownership. We crowdsourced the design and development of short films to promote HIV testing at local community-based organizations (CBOs) in China. Content: We announced a contest for one-minute HIV testing promotional videos open to all community-based organizations that deliver HIV testing in China. Judging criteria included reaching untested individuals, engaging the community, and generating excitement around HIV testing. A multisectoral (public health, medicine, anthropology, advocacy, business) panel of judges selected three finalists during an open event. Short films from finalists will be screened by a panel of film experts at the Macau International Digital Film Festival where CBOs will receive additional capacity building from technical experts to create effective short films. Summary: Open contests may provide a cost-effective, structured mechanism to promote innovation in global health. The open contest process has generated greater interest in testing programs and forged new linkages between social media/technology partners and CBOs. Implementation research is necessary to measure the benefits of this approach and compare it to other standard campaign development tools.
A framework for measuring progress towards universal health coverage

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ABSTRACT

Universal health coverage (UHC) is a catalyst for health and financial equity, and an important step towards a truly people-centered health system. Because of the wide scope of UHC, there is a need to standardize methods for measuring it. Such a framework would allow countries to measure and monitor their progress towards reaching UHC and benchmark their progress against other countries. In this paper, we propose an innovative method for generating systematic and rigorous estimates of UHC. By applying this measurement method, we generate initial estimates of coverage for 15 countries for the last two decades. Defining the range of service coverage is one of the major issues in measuring UHC. So far, the focus of measurement has been on tracking maternal and child health services and a few communicable diseases. Service coverage for non-communicable diseases (NCDs) remain unmeasured although they account for the majority of global disease burden. We focus on 20 diseases responsible for the largest share of the global burden of disease. For many maternal and child health conditions and several communicable diseases, we build upon accepted methods of estimating coverage. There is limited tracking of NCDs and injuries at the global level. As a result, we utilize estimates of prevalence and incidence from the Global Burden of Disease Study 2013 and cause-specific service utilization data, which largely come from inpatient and outpatient registries and existing surveys. We calibrate coverage estimates to reflect effective intervention coverage based on relevant data in the literature. Standardized assessments of the coverage of health interventions across countries over time are vital for monitoring progress toward UHC and for evaluating the impact of policy initiatives and processes that aim to improve UHC. Also, the possible inclusion of UHC in the post-2015 development goals will only increase demand for rigorous measurement of UHC.
Universal coverage in Northern Nigeria - half a million at a time

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ABSTRACT

With some of the world’s worst indicators for maternal and child health (MCH), Northern Nigeria is addressing the challenge of universal health coverage through a novel adaptation of the Cluster Approach for Emergency Obstetric and Newborn Care. With finance from the UK and Norwegian governments, the Partnership for Reviving Routine Immunisation in Northern Nigeria: Maternal Newborn Child Health (PRRINN-MNCH) is supporting a number of states to adapt the Cluster Approach with each cluster covering a population of approximately 500,000. By late 2013, clusters had covered 100 percent of the states of Yobe and Zamfara and approximately 50 percent of Katsina. During the course of a five year implementation period, the programme adopted three major strategies. First, there is strong emphasis on the six pillars of health systems strengthening. Second, significant effort is invested in stakeholder engagement and on the political economy of reform to galvanise local leadership in support of change. Third, commensurate investment is made in community engagement and development of community based systems aimed at creating an enabling environment. A particular emphasis of the programme was to strengthen the evidence to accountability continuum with strategic outputs related to health and demographic surveillance, operations research, social mobilisation and improved sectoral governance and accountability. A range of critical MCH indicators improved significantly in interventions sites compared to controls. By understanding the health sector in Northern Nigeria as a complex adaptive system and finding common win themes among key stakeholders, we anticipate that the full impact of the programme is yet to be realised. Looking forward, the Government of Nigeria and cooperating partners will want to take necessary action to ensure that gains achieved over the last five years are consolidated and institutionalised. If taken to scale, achieving universal health coverage in Northern Nigeria is not as unattainable as once thought.
Developing a Human Resources For Health (HRH) effort index to measure and track country level inputs in HRH

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ABSTRACT

Purpose: Current indicators used to measure efforts and progress in human resources for health (HRH) are limited and often unreliable, especially in countries with health workforce shortages. These limitations constrain country, donor, and program efforts to identify and address gaps in HRH and to track progress over time. The health worker density ratio and the health worker reach index have increasingly been used to measure HRH variables and are generally the only variables used to compare countries’ on HRH. However, both indicators are severely limited by poor data quality, especially on health worker density. There is a need for a more robust approach to assessing the complex framework for HRH in order to better inform HRH investments to engender more effective and equitable health systems. Focus/Content: The USAID-funded CapacityPlus project developed the HRH Effort Index, guided by the HRH Action Framework. Development of the index also included substantive formative research (e.g., literature reviews, an HRH implementation case study, and stakeholder interviews) and consultation with an expert advisory team prior to pilot testing in three countries. The Index’s 75 questions encompass eight dimensions: - leadership and advocacy - policy and governance - finance - education and training - distribution, deployment, recruitment and retention - human resources management - monitoring and evaluation - data and information systems. Significance for Field-Building Dimension: Implementation of this tool will allow countries and the international community to gather inputs from HRH experts in a systematized way and to: 1. Identify strengths and weaknesses 2. Measure progress over time, and 3. Compare countries Target Audience: The HRH Effort Index will enable countries, program implementers, and donors to more readily assess and measure national HRH inputs and potentially to predict workforce performance, service use, and quality.
Typologies of people-centered health systems in low- and middle-income countries: Innovations for cross-country learning

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ABSTRACT

Background To assess health system performance, create more efficient health system reforms and optimize health interventions, it is crucial to understand how health systems differ through creating typologies. Typologies have been widely used particularly in the fields of social sciences and urban planning as a similarity measure to explore mechanisms that lead to programs' successes and failures and allocate resources to those with most impact on improving outcomes. However, applying typologies on health systems analysis are yet to be explored. This is coupled with various conceptual and methodological challenges associated with health systems analysis, particularly in terms of comparative analysis to facilitate cross-country learning. Until typologies of health systems are done, misallocation of health resources and poorer health outcomes will persist. Methods This study involves comparative cross-country cluster analysis of health systems in low and middle income countries (LMICs). Using 3 data waves from the Demographic Health Surveys and World Health Surveys, we used cluster analysis to classify countries and their health systems by the most homogenous groups possible. Using World Health Organization's health systems building blocks and multivariate regression models, we identified health system characteristics that create more responsive and people-centered health systems. Results Findings provide visualizations of health system clusters and measures proximities within and among clusters. It also identifies whether countries with more likely similar health system characteristics also achieve similar health outcomes. To give possible explanations to such differences in achievement of health outcomes within groups of similar health system characteristics, other variables that may significantly influence health were also explored. Conclusions Clustering of health system characteristics facilitates cross-country learning by reducing economic and social differences among LMICs to ensure proper health systems analysis. Such typologies facilitate comparisons of health systems in LMICs and help in exploring which health system characteristics lead to better health outcomes.
Usefulness of Geographic Information System (GIS) for assessing accessibility to Emergency Obstetric and Newborn Care (EmONC) services: an assessment from 24 districts in Bangladesh

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ABSTRACT

Background: Quick accessibility to EmONC facilities (for 9 and 7 specific services from designated comprehensive and basic facilities) is important for saving lives. Accessibility to EmONC facilities depends not only on distance but also on geographic conditions and transportation systems of the region. The current UN guideline (for every 500,000 population there should be minimum 5 EmONC facilities of which at least one should have comprehensive services) considers only the population size in determining the minimum required number of EmONC facilities for a region. We used GIS application for accessing accessibility to EmONC facilities and compared the coverage with that estimated using UN guideline. Methods: We collected the satellite geo-locations of all the public health facilities designated to offer EmONC services in selected 24 districts (43.7 million population and 68,871 sq km) of Bangladesh. These data were linked with administrative boundaries, road networks, waterways, settlements and other basic mapping features to estimate average travel time to reach nearest facility. As development tools, ArcGIS Server 10.1 software was used. Results: We found, 2.5 EmONC facilities per 500,000 population which is much lower (50% coverage) than the UN recommended figure. Our GIS model estimated, 41% of the study population could reach the nearest EmONC facility within 1 hour travel time (per 100,000 population). On the other hand, the study districts had 1.2 Comprehensive EmONC (CEmONC) facilities per 500,000 population which over satisfied (120% coverage) the UN requirements. However, GIS model estimated, only 72% of the study population had access to the nearest CEmONC facility within 2 hours travel time. (per 500,000 population). Conclusions: Application of GIS for assessing accessibility to EmONC facilities revealed substantial lower coverage as compared to the figures estimated using UN guidelines. GIS application can help effectively plan the health system for improved accessibility to EmONC services.
Abortion: The hidden burden on health systems and women’s lives in Africa

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ABSTRACT

Background: Unsafe abortion is a major cause of maternal mortality and morbidity in Sub-Saharan Africa; however, not much is known about its magnitude and the cost implications of treating abortion complications on national health systems. Methods: We conducted a survey of a nationally representative sample of health facilities in Eritrea, Malawi and Niger. Case notes of all patients admitted with obstetric complications over a one-year period were reviewed to determine the case-mix of obstetric complications and causes of maternal deaths at health facilities. We further estimated the cost of treating post-abortion complications at health facilities in each of the three countries. Results: Complication due to abortion was the leading obstetric complication treated at health facilities in Eritrea (46%) and Malawi (24%) and the second leading complication in Niger (16%). About 7-24% of maternal deaths at health facilities were attributed to abortion in the three countries. The total cost of post-abortion care each year was $956,000 in Eritrea, $6.7 million in Malawi and $850,000 in Niger. Discussion: In African countries where family planning use is low, abortion is exacting a heavy toll on women’s health and is draining health budgets. Maternal health policies have not adequately focused on addressing the heavy burden of abortion. An unfavorable legal environment and stigma associated with abortion has largely kept the problem hidden. Conclusion: Increasing contraceptive use and providing safe abortion care can avert a significant proportion of maternal deaths and maternal morbidity in Africa. Averting abortion will also significantly reduce the high patient burden at over-stretched health facilities and save limited financial resources. These resources could be better utilized for emergency obstetric care provision, for example, for hemorrhage that leads to a high proportion of maternal deaths and fistula, a key cause of maternal morbidity in the region.
Planning for ART patient transfer from PEPFAR-funded to government clinics: A strategy and tools

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ABSTRACT

Background: In 2010, PEPFAR committed to funding development partners to provide technical support for health systems strengthening instead of direct support for service delivery. Consequently, PEPFAR-funded facilities, the Department of Health and development partners are faced with transferring ART patients to the public health sector - in the absence of a universal systematic plan. Recently, when a PEPFAR grant for an NGO clinic came to an end and patients had to be transferred to Free State government facilities, the Department requested that the Health Systems Trust (HST) assist with planning. In this paper, HST and the Fezile Dabi District Management would like to share the process and tools used. Methods: Transfer planning was done in three steps, firstly, a capacity and operational assessment in government facilities to absorb patients; secondly, an analysis of patients to be transferred; and thirdly, a patient transition plan. Results: The strategy facilitated a well-planned transition. Human resources and infrastructural challenges were identified and the District planned to respond to these. Patients were tracked and management and facilities were prepared for the transition. Up to 14 February, 795 patients have been transferred with a further 414 to be phased by end March. A study on patient outcomes are planned towards the end of the year to scientifically probe the continuity, quality of care and success of the transition. Discussion/conclusions: Meticulous planning is crucial to achieve a people-centred approach to the large-scale transition from PEPFAR to government facilities under way in the country, both to increase the chances of patients remaining in care and to prepare health managers and facilities for the transition. The strategy and tools used in the Free State may contribute to a reduction in ambiguity among patients, managers and facility staff involved and can be valuable in future transitions.
No opportunities missed: Strategies for functional integration of HIV/STI and sexual/reproductive health services in Peru

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ABSTRACT

BACKGROUND: Sexually transmitted infections (STI), including HIV, affect women's and men's sexual and reproductive health (SRH) overall. Commitments to foster the functional integration of HIV/STI and SRH have been adopted, but little has been implemented, in part because SRH services mostly reach married women. Populations at risk for or affected by HIV/STI do not receive SRH services. Currently the link between SRH and HIV/STI services is recognized as necessary as STIs also affect reproduction. Moreover, structural factors affecting both are similar. Strategies must be found to offer both SRH and HIV/STI services to all.

METHODS: Through documentary analysis and semi-structured interviews with clients and health providers we assessed the situation and possibilities of integration of SRH and HIV/STI services in three Peruvian hospitals.

RESULTS: Provisions to link SRH and HIV/STI services only exist for maternal and child health and aim to prevent mother-to-child transmission. Neither HIV+ people nor members of populations most affected by HIV are offered SRH services. SRH service (mostly female) clients are not offered HIV services. Men seeking general care are not offered any such services. Hospital service algorithms make functional integration difficult. Services work separately and referrals are limited and lack follow-up. HIV and SRH providers oppose integration as they fear structural changes and instability. Clients perceive that some functional integration could save time and simplify procedures.

CONCLUSIONS: SRH and HIV/STI services in Peru are not structured to favor basic forms of functional integration; rather they are settings were opportunities to reach users with complementary provider-initiated services are constantly missed. Access among men from the general population is particularly low. Strategies are needed to favor not only such functional integration between SRH and HIV/STI services, but to make those services more broadly available in other hospital services, to reach populations with virtually no access at present.
Public Private Partnerships for TB control in India: What role for social theory in health systems strengthening?

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ABSTRACT

Background: Public Private Partnerships (PPP) are increasingly utilised as a public health strategy for strengthening health systems. Processual evaluation of these partnerships have focused on global and national level partnerships with less attention paid to how individual partnerships are put into practice at the local health systems level. Partnerships are complex systems that rely on relationships between a myriad of different actors with divergent agendas and backgrounds. To understand them a multi-disciplinary perspective that draws on insights from social theory is needed. This study fills this gap by analysing implementation processes relating to Public-Private Mix (PPM)-TB policy in India, with a focus on the district level. Methods: In-depth ethnographic research was conducted over a 14 month period, combining participant observations, informal interactions and in-depth interviews with a wide range of respondents across public, private and non-government organisation (NGO) sectors. Results: Drawing on the theoretical insights from Bourdieu's 'theory of practice' and Lipsky's 'street level bureaucrats' this study explores the relationships between the different actors. The study found that programme managers, frontline TB workers, NGOs, and private practitioners all played a crucial role in TB partnerships. They were widely regarded as valued contributors with distinct social skills and capabilities, within their organizations and professions. However, their potential contributions towards programme implementation tended to be misrecognised both at the top and bottom of the policy implementation chain. They constantly struggled for recognition and used different mechanisms to position themselves vis-a-vis other actors within the program. Different perceptions of each other and inadequate communication further complicated the relationships between different actors. Conclusion: The study demonstrates the impact of utilising social theory to build frameworks that allow us to gain a better understanding of the complex relationships within health systems. Such a framework can improve partnership implementations and strengthen health systems for the future.
Mobile urgent Maternity services (MUM): A model for optimizing EmONC resource allocation

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ABSTRACT

Background: Timely access to emergency care for pregnancy-related complications can mean the difference between life and death for mothers and newborns. Distance, combined with the lack of, or cost of, transport, is a key barrier, as noted in a number of studies in Kenya, and contributes largely to her high unmet needs for Emergency Obstetric and newborn care (EmONC).

Purpose: The MUM project seeks to address physical distance as a barrier to EmONC services, by comparing the cost effectiveness of different, optimally distributed EmONC resources in Kenya (including static clinics, ambulances and mobile clinics) and making recommendations for the optimum placement and mix of these EmONC services, to increase access of these services to women of childbearing age.

Methods: MUM is 2-phased. In Phase One (Baseline Analysis and Static Optimization), data was used to understand geographic access to EmONC services by women and consequently how EmONC access could be improved through the addition of optimally located static clinics with and without ambulance services in each county. In Phase Two (MUM Optimization) the partners focused on Kilifi County, Kenya, to determine the benefit of adding optimally routed mobile "MUM" clinics for maternity care.

Results: The baseline analysis resulted in mapping of the percentage of women of reproductive age within two hours walking time of their closest secondary or tertiary facility in Kenya while the static optimization analysis determined the demand of EmONC complications met for every additional static facility per county in Kenya. Critically it was noted that none of the demand was met 100% by the static clinics in any of the counties. The preliminary results from the MUM optimization analysis indicate that there was a significant addition of the demand met with the addition of mobile "MUM" clinics in each of the counties in Kenya.
Hospitals without corruption - Scaling up anti-corruption measures and promoting social accountability through action research

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ABSTRACT

Background Corruption has a significant, negative effect on health indicators such as infant and child mortality, even after adjusting for income, female education, health spending, and level of urbanization (Gupta et al 2002). Although grand corruption and embezzlement might influence overall health spending, evidence suggests that corruption in form of informal payments for care directly reduce access to services, mostly for poor people. Therefore health systems with high level of informal payments must address this with appropriate measures in order to create a solid foundation for patient-centered health system. Serbia has highly corrupted health system, with over 45% of citizens perceiving doctors to be corrupted. (UNDP 2014)

This action research intervention is directly addressing informal payments in health care sector by promoting integrity, increasing accountability and citizens' participation in monitoring healthcare institutions. Purpose of this intervention is to reduce informal payments in health care facilities in Serbia and improve citizens' participation in decision-making process by creating and piloting 3 anti-corruption measures in 5 hospitals in Serbia. The intervention is accompanied by research conducted among discharged patients on informal payment practices and perception of corruption. Implementation 5 Hospitals were selected based on voluntary commitment by management to reduce informal payments and increase accountability. Pre-intervention research was conducted among 250 randomly selected discharged patients from high-risk wards. During the 2-month period three anti-corruption measures were implemented: 1. Information about anti-corruption mechanisms was provided in all waiting rooms and doctors offices 2. Specialized integrity trainings for minimum 80% of physicians and nurses were organized 3. Representative of local patient organizations was included as observer on hospital Board meetings After two months (May 2014) exit research will be conducted to evaluate project impact. We expect the results to show improvement on both perception and informal payments practices among hospital patients.
Community engagement for people-centred health systems: Insights from action research in maternal health and rights in India

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ABSTRACT

Background: It is clear that communities are important partners in - and beneficiaries of - people-centred health systems. What is less clear is the question of how communities are to be defined in divisive contexts marked by rigid social hierarchies and identities. And how such communities are to be mobilised around health issues. In our presentation, we grapple with the complexity of communities in order to take forward the idea of people-centred health systems. Method: We draw upon insights gained from an action research project on maternal safety and rights in Koppal district, Karnataka. The project occupies the institutional interface of the community and the public health system and seeks to: a) Generate awareness in the community and empower its members to demand quality services from public health providers. b) Increase access of pregnant and postpartum women to quality services. c) Strengthen accountability of public health care providers to women's health needs. The project carries out a combination of research (verbal autopsies, operations research) and actions (pressure groups, a helpline, an obstetric risk management system, a newsletter, community awareness programmes, and training for adolescent girls). Findings: - Communities are built around shared identities rather than geographical boundaries: distinct communities can reside together. Community engagement is therefore a many-layered process. - Childbearing women and adolescent girls can be reluctant participants due to time constraints (from punishing workloads and precarious livelihoods) and the lack of permission, unless their participation materially benefits the men in the family. Building consensus and mobilising men for maternal health and rights requires sustained and multi-pronged strategies. - Working with communities requires more time than is often available. There can be no quick fixes. - Health systems do not respond to the community unless they are mandated to do so. Hence, action is required at different levels to make health systems responsive.
Documentation of deaths by local communities to counter severe under-reporting of deaths by government: Experiences from a community based monitoring process from India

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1 State Health Resource Center, India

ABSTRACT

National Rural Health Mission (NRHM) in India has promoted Village Health Sanitation and Nutrition Committees with the aim of promoting participation of rural communities in monitoring, planning and action on local health. These village level committees are mandated to record the deaths in the villages. In 2012, information on 40,000 rural deaths was thus recorded, along with the probable causes reported by families, in 'Community Death Registers' by around 12,000 local communities in state of Chhattisgarh. The communities discussed and analysed this information in their monthly meetings facilitated by Trained Facilitators. It enabled communities to assess the deaths they can prevent and the steps they can initiate to achieve that. It served as an instrument with which the communities could monitor the health system. The information on 40,000 deaths was also compiled at state level. These deaths constituted around 25% of total expected deaths. It identified the common causes of deaths amongst different age groups. Malaria emerged as a major cause of deaths across age groups up to 60 years. While the State Government had reported around 10 deaths due to malaria, the Community Death Registers documented nearly 2,500 deaths related to fever. This brought to light the gross under-reporting of malarial deaths by the State Department of Health. The magnitude of malarial deaths also partially explained the exceptionally high child mortality in some districts of the state. The report also documented accidents and suicides along with TB as other leading causes of deaths in adult population. This experience shows the ways to empower rural and indigenous communities with low literacy and high poverty levels, in monitoring and analysing mortality data and also in putting forward the evidence to counter chronic under-reporting of deaths by Governments.
Thinking on your feet: the challenges of evaluating maternal, neonatal, and child health programs shaped through design thinking and human-centered approaches

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John Snow, Inc

ABSTRACT

The Innovations for Maternal, Newborn and Child Health Initiative applied the principles of human centered design and design thinking to improve the relevance and effectiveness of four pilot Maternal, Newborn and Child Health (MNCH) interventions. Design thinking includes deliberate and frequent involvement of end users in problem conceptualization and the design of a health intervention as well as iterative planning and implementation. In the context of increased demand for evidence and rigorous performance evaluation, the use of design thinking for social innovation presents several challenges to accepted approaches to program implementation, monitoring and evaluation. This paper uses the experience of two pilots - Essential Newborn Care Corps (ENCC) and Care Community Hub (CCH) - to illustrate the tensions and trade-offs inherent in combining iterative and nimble monitoring strategies to ensure greater adherence to user needs with traditional public health program evaluation approaches. Lessons gleaned at the midpoint of each pilot are critiqued and practical steps defined for program designers, managers and evaluators.
Health systems barriers to the implementation of innovative monitoring systems for STI partner notification

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ABSTRACT

Background Partner notification is the cornerstone of sexually transmitted infections (STI) control and management strategies. However, in the South African context partner notification is not rigorously monitored by health service facilities. To strengthen health service capacity to monitor STI partner notifications outcomes in Khayelitsha Health District (Cape Town) we formed a partnership with local health authorities and experts in information health systems, to develop a new, improved and innovative monitoring system for use at three clinics in the district. This paper aims to describe barriers to the implementation and uptake of a new STI Partner Notification Monitoring System in a major health district in Cape Town. Methods We conducted audio recorded qualitative interviews with one district manager, two facility managers and two sisters-in-charge of the three clinics that were targeted with the new monitoring system. Findings The district manager reported extensive participation in the conceptualization and design phases of the new STI Partner Notification Monitoring System. However, despite the high level of involvement and thus presumed ownership of the final product, the new system was not implemented in the district. Key barriers to implementation included the district health system's poor capacity to sustain new, innovative systems in the context of human resources challenges, including high staff attrition due to high, internal staff transfer rates; lengthy staff replacement leg time; poor handover processes between old and new management; lack of basic technological devices and the introduction of too many new systems all at once. Discussion Human resources strategies that promote transfers and movement of staff within the broader health system need careful thinking, as they may have the unintended consequences of undermining local health capacity to implement and sustain new, innovative projects. The basic infrastructure of the local health system needs to be strengthened before new innovations are introduced.
Using nonparametric methods to develop robust and flexible ranking of district health systems performance

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ABSTRACT

Background: Ranking and measurement of health systems performance can be an effective advocacy tool, highlighting inequities in need of redress, engaging and motivating both health workers and decision makers to address health system deficits that don’t meet the needs of people, and guiding appropriate managerial and planning actions. Given vastly different contexts and disease burden at sub-national level, effective ranking tools need to allow for adjustment according to available resources and contextual challenges faced.

Methods: A free disposal hull procedure was adapted to compare the performance of South Africa’s district health systems across a large set of effectiveness and efficiency indicators. A resampling technique was applied (1) to overcome the loss of discriminative power affecting non-parametric methods when the number of indicators is large and the number of elements to be compared relatively small; (2) to improve the robustness of the estimates with regard to the choice of indicators; and (3) to calculate confidence intervals for the performance scores. The procedure was repeated taking into account differences in input resources (per capita expenditure). Finally, the results were adjusted for contextual socio-economic variables and disease burden.

Results: Without arbitrary decisions on relative weights of the indicators, the proposed methods provided performance scores reasonably robust regarding the choice of the indicators and the presence of imprecise values. The adjustment for input resources and contextual variables enabled fair comparison of performance.

Discussion/significance: Attempts at ranking and performance assessment are not new, but improved computing and statistical approaches enable reduced reliance on potentially biased opinions on relative weights; are more robust to measurement error and customisation of included indicators; and have greater adaptability to different contexts and changes in monitoring and evaluation priorities over time. This will enable use of more accurate and easily interpretable data to inform health decisions.
ABSTRACT

Purpose The Lungisa project empowers ordinary people in lower-income Cape Town communities to report service delivery issues using various mobile phone platforms. Lungisa then channels these reports to local government officials for action. Both feedback and support are provided to community members. The project publicly identifies areas with poor service delivery. Focus/content Lungisa makes it simple and easy for everyone, especially the marginalized and poor, to monitor and send reports (including photos) on service delivery problems. Reports are made through various mobile phone-based technologies (USSD, SMS, Mxit, Facebook) or are directly uploaded at www.lungisa.org. Lungisa is advertised through multiple channels which include radio, posters, pamphlets and community based NGOs and volunteers. Service delivery problems are publicized through a web-based database. More than half of reports are related to health or sanitation. The public, government officials and other NGOs can view and comment on reports on the Lungisa website so to add support and/or context. Lungisa's reporting channels are secure and confidential. Those reporting issues receive an automatic reply thanking them for submitting the report, with a reference number so to track the reported issue, monitor progress, and see responses from duty bearers. Significance to field Lungisa improves the transparency of the service delivery process, and allows local community members to potentially monitor how services are delivered. It closes the feedback loop by following-up on reports and reporting back to the community. Target audience Local community mobile phone users, local government managers.
Integration of health services and systems - a policy analysis framework to study integration at country level.

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ABSTRACT
Integration has emerged as salient concept in health policy and systems research, partly due to the need for greater efficiency and cost reduction given the contraction in global health funding. However, with many competing definitions of integration there are few frameworks for research or analysis on 'integration' of services with health systems. This limits the empirical knowledge base on what works in terms of integration and why. This paper proposes a policy analysis framework for the study, conceptualisation and better understanding of integration of specific services (for example disease specific programmes for HIV) with the overall health system. Authors developed the framework as part of research which examined conceptualisation of integration of services with health systems and strategies to either fund or implement this at country level. The research focused on global health organisations such as the World Bank, WHO, the Global Fund and GAVI. To allow for more and comparative empirical research and evaluation of integration we propose a framework for analysis consisting of actors, motivation for integration, the intervention, and the health systems context. 'Actors' refers to national policymakers, implementers and health workers. It also refers to the proponents or policy entrepreneur 'pushing' or proposing integration. This may be a funder, such as the Gates Foundation or a technical agency such as WHO. 'Motivation' is taken to mean the intention driving integration. 'Intervention' is the strategy or policy through which integration is incentivised. 'Health systems context' includes the financing and other contextual factors such as the human resources for health or procurement systems. The framework envisages these as interactive parts of a dynamic process. The framework presented provides a methodology for much needed empirical research on integration of services with systems to provide practical knowledge to policymakers and funders seeking to support such integration through their programmes.
Developing a mixed-methods approach to identify and address complex financial and non-financial barriers to Universal Health Coverage

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ABSTRACT

Background: The study evolved from a larger project that seeks to synthesise existing knowledge on equity in access and on the operationalisation of Universal Health Coverage with equity in district health systems. The objectives are to develop systematic methods to identify, assess and address non-financial access barriers, to apply these methods to generate actionable data for district managers and to embed the approach into district health systems strengthening (DHSS). The methods seek to address the significance of socio-cultural determinants and decision-making practices with regard to access and utilisation of health services. Methods: Structured literature reviews on qualitative and quantitative approaches to financial and non-financial access barriers for maternal and child health services in Ghana, Rwanda, Bangladesh and Vietnam were conducted and findings synthesised to inform the design of a mixed methods approach. Scoping studies, focusing on skilled birth attendance and immunisation as tracers, were then undertaken with partner institutions in Ghana and Rwanda to assess the technical and institutional feasibility of using this mixed-methods approach to support DHSS in LMIC contexts. Results: The study highlights the added value of systematically combining qualitative and quantitative data in an approach to strengthen equity-oriented DHSS policy in complex health systems. The results of the scoping studies suggest that country-specific factors need to be taken into account in the implementation of a mixed methods toolkit for district health managers. Discussion/conclusions: In both Ghana and Rwanda, limited access to and utilisation of mother, newborn, and child health services are the result of the complex interaction between multiple determinants. Distributed leadership and a degree of autonomy among front-line health workers and sub-district managers are associated with increased innovation and greater willingness to consider people-centred approaches. This study synthesises the evidence using qualitative and quantitative data and highlights the relevance of peer-to-peer interaction and knowledge transfer.
Developing a systems-based framework to assess the impact of the organizational-level financial mechanism on provider behavior in the hospital setting

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ABSTRACT

Background Evidence on the impact of organizational-level financial mechanism on provider behavior is scare. This study aims to propose and pilot-test a systems-based framework to assess impact of the organizational-level financial mechanism on provider behavior in the hospital setting. Methods The framework was established by synthesizing theoretical and empirical evidence of applying systems theories such as systems dynamics on health interventions. Using case study approach, the framework was pilot-tested in a Chinese county. Tuberculosis care, previously provided by TB program, was recently integrated in a 'designated' public hospital to improve 'people-centeredness'. However, this hospital received no government funding to support the newly integrated TB unit (financially 'self-sustaining'). The study methods included patient chart review, in-depth interviews and causal loop diagraming. Results The framework encompasses organizational-level financing mechanisms and management processes, both interacting to influence provider behavior. The intermediary management processes include inter-connected sub-blocks of health governance, resources management and organizational culture. Integration did not necessarily improve the 'patient-centeredness', with a high level of irrational prescriptions for uncomplicated TB cases including prescription of non-TB drugs (71%), CT (89%) and hospitalization (16%) ('unintended consequences'). Recent policy of zero markup of essential drugs may limit prescription of drugs ('balancing loop'), but not for hospitalization and medical investigations like CT. Non-liner relationships were found between the financial mechanism and prescription behavior. Lack of government funding ('self-sustaining' mechanism) demotivated hospital management to improve the distorted 'performance-based' bonus systems, dominating medical culture and lack of clinical governance and training on TB care ('reinforcing loop') - which influenced prescriptions. Conclusion The proposed systems-based framework, further amplified with a causal-loop diagram is useful in evaluating systems-level interventions, especially in identifying complex and dynamic relationships, key determinants and contextual-level factors that affect the achievement of 'people-centeredness'. This study will contribute to improving the operational concepts and frameworks for the WHO-recommended systems-based thinking, currently remaining abstract and theoretical.
Vulnerability and resilience: the importance of social relationships to health

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ABSTRACT

The aim of this paper is to explore the influence of social relationships on beliefs and practices around health. We argue that social relationships and aspects of social capital, can be a force that supports or challenges healthy behaviour. The research was carried out in Northwest of Tanzania, Ngara district, which is located at the borders of Rwanda and Burundi. Ethnographic enquiry was adapted in collection, analysis and interpretation of findings where by observation (data collection), ground theory (analysis) and phenomenology (interpretation) techniques were applied. The findings show that for the participants, maintaining good social relationships is more important than taking action to protect individual health. In addition, the relationship between the villagers and health professionals has a significant impact on their willingness to accept information about health. We discuss how social relationships can act as a barrier to healthy choices and reinforce the vulnerability of the population to health risks, and how they can also in other circumstances be a force that improves health and resilience to disease. These findings are relevant to health systems as they inform importance of social relationships in developing culturally appropriate people-centred systems.
ABSTRACT

Background and purpose Socio-cultural factors influence health by affecting exposure and vulnerability to disease, the ability to seek and treatment and the effectiveness of healthcare. They determine to a large extent people’s perceptions and responses to utilizing healthcare. At the macro level, these factors include understandings of illness, healthcare and the organizational, social and economic context of health care services. At the micro level, influences include the face-to-face interaction at service level and successful or failing communication. Explanatory models (EM) show clients’ beliefs about their illness, the personal, social and economic meaning they attach to their health problem, and the expectations about their treatment. Comparing the healthcare client EM with that of healthcare provider and the health insurer will allow identifying discrepancies between the three EMs. This may help explaining certain challenges in service provision and enrollment. Our research presents data from a study in Ghana, collected in 2011 aimed at identifying barriers to enrollment in the National Health Insurance Scheme (NHIS). Method A qualitative methodology was adopted to record the views of clients (225), primary healthcare providers (22) and NHIS staff (19) in their own environment. We analyzed (NVivo-9) and compare differences in perceptions and beliefs on barriers to access healthcare and health insurance services and examine the sources of any disparities, building upon the three EMs. Results and significance The study reveals differences in EMs between the three stakeholder groups at macro and micro level and the power relations. This comparison helps healthcare providers and NHIS to identify which aspects of their EM needs adaptation or clearer exposition to clients and the wider community, and what improvements are most appropriate. Once the different EMs have been made explicit, it facilitates negotiations on the best solutions to reduce barriers. Identifying and understanding these disparities contributes to the science and practice of people-centered systems.

Barriers to enroll in health insurance - disparities between explanatory models of health insurer, healthcare provider and client

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Are there inequalities in community-based interventions for maternal health? The case study of women groups in Mchinji district, Malawi

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ABSTRACT

Background In Malawi and Nepal, community mobilisation through women's groups reduced MMR by 74\% and 88\% respectively. In addition, meta-analyses of seven randomised control trials (RCT) conducted in Malawi, India, Nepal and Bangladesh showed that exposure to women's groups is associated with a 37\% reduction in maternal mortality and 23\% reduction in neonatal mortality. So, just like primary and secondary health-care, community mobilisation approaches can also improve the health of the mothers and children. However, what is not clearly known is whether these locally initiated interventions reach all women equally.

Objectives To investigate if inequalities exist in community mobilisation or people-centred approaches for health. Methods Data was collected from both members and non-members of women group community intervention for maternal and child health in Mchinji using qualitative tools. In particular, 26 focus group discussions (FGDs) were conducted with women aged between 15 and 59. In-depth interviews were also conducted with three community key informants. All participants were purposively recruited. All the interviews were transcribed, translated and transferred into Nvivo for analysis. Results Although little, if any, socio-economic inequalities in accessing women groups were identified, significant differential reach between the following groups was observed: married and unmarried, young and old and educated and uneducated among others. While women who are married, young and uneducated are particularly at a higher risk of maternal mortality, women group intervention was not able to comprehensively reach them.

Conclusion and Recommendations Inequalities exist even in community-based interventions for health. We recommend that community interventions should be accompanied by massive community awareness campaigns and men needs to be involved. In addition, it looks like 'one size fits all' type of community interventions may not yield the best results; customised groups and or interventions for young women are consequently recommended.
Community-based care is associated with lower levels of internalized HIV/AIDS-related stigma among people living with HIV/AIDS in the Kathmandu Valley, Nepal

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ABSTRACT

Background: Stigma is an important bottleneck in HIV prevention, care, and treatment. In addition to devastating the familial, social, and economic lives of individuals, HIV/AIDS-related stigma has been linked with factors that undermine ART adherence, including HIV serostatus disclosure, social support, and mental well-being. In this context, experience of home-based care (HBC) may play an important auxiliary role as social capital, helping to reduce internalized stigma among people living with HIV/AIDS (PLWHA). Methods: This cross-sectional study surveyed a community-based sample of 322 adult (20-60 years) PLWHA residing in the Kathmandu Valley, Nepal, using a structured, pre-tested Nepali language questionnaire with face-to-face interviews. Data were analyzed using multiple logistic regression models to examine the association between internalized HIV/AIDS-related stigma and receipt of home-based care services in the past 3 months, adjusting for potential confounders. Internalized stigma was assessed by a modified 6-item version of a theoretically based and psychometrically sound scale measuring respondents' acceptance of common community-held stigmas. Results: Overall, 69% of surveyed PLWHA reported difficulty in telling others about their HIV status and 67% reported hiding their status from others, while 44% reported feeling 'dirty', 48% 'guilty', 48% 'ashamed', and 55% 'worthless' because of being HIV-positive. Meanwhile, 28% had received home-based services or a visit from an HIV/AIDS-related NGO staff member in the past 3 months. Such individuals were significantly less likely to report higher (above-median) levels of internalized HIV/AIDS-stigma (AOR=0.54; 95% CI 0.31, 0.92; p=0.03). Discussion: Findings add to the growing body of evidence suggesting that HBC can have positive social outcomes toward meeting the challenges of up-scaling care to PLWHA, especially in low- and middle-income countries. Further strengthening and scaling up such community-based programs may help to alleviate the burden of stigma among PLWHA in Nepal and similar settings, thus contributing to improved HIV prevention and treatment outcomes.
Assessing implementation fidelity of a community-based child nutrition intervention in Ethiopia identifies delivery challenges that limit reach to communities

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ABSTRACT

Background: Implementation fidelity is defined by adherence to intervention design, exposure or dose, quality of delivery, and participant responsiveness. As part of the process evaluation (PE) of Alive & Thrive, a large-scale initiative to improve infant and young child feeding (IYCF), our study assessed the four elements in training of frontline workers (FLWs), delivery of program tools and messages, and supervision and feedback. Methods: Data from a qualitative study among three levels of FLWs (n=54 in 2012), i.e. supervisors, health extension workers (HEWs), and community volunteers; and baseline and PE surveys with FLWs (n=225 in 2010, n=504 in 2013) and mothers (n=1,481 in 2010, n=750 in 2013) in two regions (Tigray and SNNPR) were analyzed to examine fidelity of key program components. Results: There was strong adherence to intended cascading format (i.e. knowledge and skills transfer from higher to lower FLW levels) and high exposure to training (95% HEWs and 94% volunteers in Tigray, 68% and 81% respectively in SNNPR). Training quality, assessed by IYCF knowledge and self-reported capacity, was high and increased since baseline. Job aids were used regularly by most supervisors and HEWs, but only 54% of volunteers in Tigray and 39% in SNNPR received them. Quality of program message delivery was lower among volunteers, and aided recall of key messages among mothers was limited. Although FLW supervision exposure was high, content and frequency were irregular. Conclusions: There is evidence of strong fidelity in training and delivery of tools and messages at higher FLW levels. However, limitations in HEW-to-volunteer links and variability between regions could limit the potential for full intervention reach. Our study identifies gaps and opportunities to enhance intervention reach and impact in the communities. Acknowledgment: Funded by the Bill & Melinda Gates Foundation to Alive & Thrive, managed by FHI 360.
How a family-centred information system strengthened a community health program: findings from the Community Health Information System (CHIS) assessment in SNNPR, Ethiopia

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ABSTRACT

Background The CHIS is part of the HMIS scale-up effort in SNNPR, a pivotal component of the HSDP in Ethiopia. The CHIS is used by Health Extension Workers (HEWs) at community health posts, replacing registers with Family Folders, and introducing mechanisms that support better delivery of community health services by the HEW. Methods Case study methodology was used to understand how the CHIS was working. Program theory framed case selection, data collection, and analysis. Cases represented the range of CHIS implementation situations. Data collection generated information on: functionality; user-friendliness; quality of information; use of information; work environment; effect on services. Data analysis focused first on understanding evidence from cases implementing for the shortest amount of time and contrasting cases implementing the longest. We explicitly examined contextual factors, systematically validated findings across cases, and tested alternative explanations. Findings were 'member-checked' with program implementers, health system managers and policymakers. Results We identified critical pre-conditions for CHIS functionality. Contextual factors were less important than hypothesized, and only at the pre-conditions stage. This was important for conceptualizing CHIS scale-up: focus on ensuring consistent knowledge, materials supply, and supervision is required for a short time (3-5 months). We found CHIS benefits were wide-ranging, and realized early, at many levels: HEWs saved time; forged better partnership with the communities they served; supervisors gained confidence in HEW work and data quality, as did community members; HEWs used CHIS features to plan service delivery and felt better about their work. Discussion/Conclusions We believe better information, generated by better information systems, contributes to a range of health systems improvements, but have little evidence to support this belief. We present evidence on how benefits are gained from a family-centred community-based health information system, the diversity and system-wide reach of those benefits, and the immediacy of their realization.
Linking community and health facility for better newborn care: delivery notifications and timing of post-natal visits in rural southern Tanzania

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ABSTRACT

Abstract: Background: Community health volunteers have potential to improve newborn care practices in rural low-income settings. As many newborn deaths occur in the first 48 hours of life, a timely postnatal visit is critical, but volunteers may not be aware of the birth, particularly where facility delivery is common. We introduced a delivery notification slip, to be given to women who deliver at facility or those who attended a facility shortly after a home birth. The slip was designed for the mother or relatives to take to the volunteer, within the context of a large cluster-randomized study of home-based counseling for improved newborn survival. The volunteers made a total of five home visits, three antenatal and two postnatal. Here we present the effect of the delivery notification slip on the timing of home-based postnatal visits, by comparing those women who received a slip with those who did not. Methods: As part of a large end-line household survey in July-October 2013 to assess the effect of home-based counseling on newborn care and survival, a representative sample of women were asked about their experience of knowledge, access and use of a notification slip, as well as whether and when they received a home-based post-natal care visit. Results: Preliminary results suggest that 36% of women who delivered in facility received a notification slip and 84% of these slips were given to volunteers. 33% of women who received notification slips had a postpartum visit within 2 days of delivery, in comparison with 17% of those who did not receive a notification slip (odd ratio of 2.1, 95% CI 1.8-2.4). Conclusion: Community involvement through handling of notification slips can improve postnatal visit timing, which provides a chance to save newborn lives.
Determining the cost-effectiveness of task shifting to Community Health Assistants (CHA) on health service provision in Zambia’s rural areas: a difference-in-difference evaluation

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ABSTRACT

Background: Following the August 2010 launch of a National Community Health Strategy by the Zambian Ministry of Health (MOH), Community Health Assistants (CHA), the inaugural class of 307 CHA completed one year of training and deployed to their communities in June 2012. This evaluation examined the impact of shifting the delivery of basic uncomplicated health tasks to the new CHA cadre. Methods: This evaluation used a difference-in-difference design to measure the impact of the CHA program on the volume and type of health services provided at health posts and the health centers to which they refer patients. Monthly health service provision data was collected for one year prior to and one year after CHA deployment. A total of 384 months of facility-level health service provision data was collected from eight health posts in four districts, along with their eight referral health centers. Seasonality, changes in non-CHA staffing, and periodic regional child health campaigns were controlled for in the analysis. Training and salary data for CHAs, nurses, and midwives were collected for cost-effectiveness analysis. Results: Deploying two CHAs to a health post led to an average of 164.5 additional health services being provided every month, including 38.9 child outpatient health services and 9.2 first antenatal visits. Adult OPD services decreased at health posts, shifting to health centers. The deployment of CHAs to health posts allowed more highly trained staff at health centers to provide more of the complicated services they are trained to provide. Conclusion: The addition of CHAs in rural areas increases health service provision at health posts and shifts the burden of basic health services away from more highly trained health workers. No single cadre dominated in terms of cost-effectiveness, and the most balanced impact may be achieved by deploying a combination of cadres, with a strong skills mix, including the ability to provide preventative health services at the household level. Further analyses will investigate the optimal skill mix of cadres for MOH investments under budget constraints.
Measuring the impact of a micro-social franchise scheme on TBAs: service provision and their relationship with the community in Sierra Leone

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ABSTRACT

Background: Sierra Leone has one of the highest maternal and neonatal mortality rates in the world. A 2010 policy change disallowed traditional birth attendant (TBA) led childbirth, yet one in four births occurs at home. The Essential Newborn Care Corps (ENCC) pilot explores the potential to leverage existing trust and status of TBAs within communities and rebrand them as MNCH health promoters to ensure quality care for pregnant women and newborns during home visits, while using a micro-franchise social enterprise (MFSE) model to provide an alternative source of revenue. Methods: The project compared two groups of TBAs: one that received structured training for MNCH and the other that received structured training for both MNCH and MFSE, in Bo district. A difference-in-difference approach will assess the effectiveness of these two interventions on key MNCH health outcomes when comparing the intervention groups to a comparison group in the same district. Monitoring data on goods sold, health messages and referrals provided by TBAs and qualitative data on acceptance of the new role of TBAs by the community and TBAs themselves will also be collected. Results: This paper presents evidence on the impact of implementing an innovative approach to strengthening the cadre of TBAs as health promoters for MNCH. It is expected that TBAs will retain their standing in their communities and will appreciate the opportunities of micro-franchising to create alternate sources of income. In particular, the results will provide evidence on key opportunities for strengthening health programs utilizing TBAs. Discussion/Conclusions: This paper will provide evidence on the impact of an alternative approach for rebranding TBAs, who are key actors in the Sierra Leonean health system, as MNCH health promoters in an effort to improve key health outcomes for mothers and newborns in a low-resource setting. These results will provide evidence for expanding this approach in similar settings.
Lessons learned from a three district trial of community-engaged emergency referral systems-strengthening in a remote, impoverished setting of northern Ghana

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ABSTRACT

Introduction: Globally, approximately 800 women die from pregnancy- or childbirth-related complications around the world daily. Most of these deaths could be prevented if women received timely care during medical emergencies. However, social barriers to facility delivery, poor service quality, and communication and transportation constraints continue to impede access to care in resource-poor settings. While Ghana has a well-organized, decentralized health system, the country lacks clear policies or guidelines for developing or providing emergency referral services. Methods: In March 2012, the Ghana Health Service (GHS) launched an emergency referral pilot in collaboration with community stakeholders and health workers in one sub-district of the Upper East Region—the poorest, most remote region of the country. Based on lessons learned from the pilot, the project was scaled up to 12 sub-districts in three districts as the Sustainable Emergency Referral Care (SERC) initiative for testing the hypothesis that a contextually adapted approach to emergency management improves access to care and reduces risk in rural, impoverished communities. A Motorking fleet was procured and strategically placed at subdistrict and community service points to ensure that all intervention areas have access to an ambulance. Communication is facilitated by the distribution of mobile phones to health workers and volunteers. Implementation research is being conducted with community stakeholders, health workers, and supervisory staff to better understand the challenges with implementation processes. Results: A process evaluation of the scale up project indicated challenges related to inconsistent documentation practices; varying levels of driver and staff motivation; and issues with protocol adherence. Refresher trainings with enhanced community engagement have been initiated to address these issues. Conclusions: Despite challenges, SERC has been effective in reducing maternal mortality, improving the acceptability and accessibility of facility-based care, and reducing delays in implementing emergency referrals. Community-engaged cost recovery mechanisms represent a sustainable approach to supporting operations.
Community systems for maternal, newborn and child health framework

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ABSTRACT

Purpose: As part of a broader maternal, newborn and child health (MNCH) research project the main purpose in developing the community systems for health framework is to facilitate a better understanding of community factors underpinning MNCH services in Malawi, focusing on the health dimensions of the first 1000 days of life. Focus/content: A review of existing health and community systems frameworks in relation to health systems, community systems, MNCH and social determinants of health was undertaken. The aim was to consolidate the different conceptualisations and approaches which already exist and from this to draw upon aspects, concepts and ideas which will assist in understanding community systems in relation to access of MNCH services. From this literature and the reviewing of its relevance a draft community systems framework was developed. This framework focuses on community systems and actors and adopts a multi-level approach that seeks to understand the social environment/social capital in which people live and how the connected formal and informal systems and networks are weaved together in relation to access of health services at community level. The research is continuing in moving from the conceptual to the practical stage to provide Malawian case studies on how the different dimensions and levels within the system interact. Significance: While there is some evidence to show barriers to accessing MNCH services in published and grey literature, almost all of the evidence focuses on individual barriers and in particular the ‘Three Delays Model’. We aim to move beyond the individual factors and barriers to accessing MNCH services to a community systems perspective. Recommendations will be made (to NGOs, government and donors) for utilisation of a community systems strengthening approach in further interventions or programmes. Target audience: We expect this topic to be relevant to development workers, researchers and practitioners interested in community development and health.
Harnessing the potential of formally trained community health extension workers in improving newborn survival: evidence for ensuring policy implementation in Nigeria

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ABSTRACT

Background: Community Health Extension Workers (CHEWs) with two to three year formal training are supposed to spend 80% of their time in the communities practicing community based health care including home visit. Over the years, this role has been neglected. The current research evaluated the potential role of CHEWs in the implementation of community based newborn care package (CBNC) and the impact on newborn survival in Nigeria. Methods: A pre intervention pilot survey was conducted prior to a longitudinal cohort study using CHEWs to implement CBNC package in a programmatic setting in two Local Government Areas of Oyo State Nigeria between 2011 and 2013. The CHEWs were also trained on World Health Organization CBNC package and young IMCI module. Each CHEW covered a population of 6,000 -8,000 people doing pregnancy and birth surveillance, two home visits in pregnancy, post natal visit on days 0, 3, 7 and then weekly until day 60, referral of babies with danger signs and treatment of possible serious bacterial infection (PSBI) when referral was not possible. Results: Pre intervention, less than 5% of mothers had pre natal and post natal home visits with a neonatal mortality rate (NMR) of 20/1000. All newborns with danger signs were referred to secondary or tertiary centres with 60% refusal of referral. In the current study, a total of 20,939 pregnant mothers and 20,512 newborns were followed up over the study period. Mothers that had at least one visit in pregnancy were 15,249 while 16,406 newborns had at least half of the scheduled visit. Total Still birth was 474 while 1901 were found to have danger signs out of which 656 accepted referral, 1245 refused referral and 952 were treated for PSBI and NMR of 9.7/1000. Conclusions: Enforcing the community health responsibilities of CHEWs in Nigeria will improve newborn survival. (Sponsored by WHO)
The roles of village health volunteers (Posyandu kader) in maternal and child health program: Linking health systems and community in Indonesia

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ABSTRACT

Background: Integrated health service post (posyandu) is a community-driven health effort to facilitate the community to access basic health services. Efforts to improve the function of posyandu is the responsibility of both government and community, including village health volunteers (kaders). Kaders were trained to engage in Posyandu activities: antenatal and postnatal care, child growth monitoring and immunization. We examined their role to deliver health promotion and preventive services to the community with a focus on maternal and child health. Methods: Using a qualitative study we obtained information on kader selection, training and their tasks in Posyandu. Trained staff visited 8 villages in SW Sumba and Cianjur district and interviewed kaders, village midwives, mothers, Traditional Birth Attendances, and heads of village using semi-structured interviews and focus group discussions in September and December 2013. Findings: The main role of the kaders is to organize Posyandu, weigh children, assist with registration and provide health education. They also encourage pregnant women to attend health facility for deliveries, do postnatal care visits, and advise on family planning. Overtime their role has expanded and in Cianjur some kaders are trained to assist midwives during delivery and in neonatal care. Kaders are mostly chosen by the village elite. This practice is changing by the village midwives who increasingly chose kaders to assist them. Although kaders are volunteers provided with modest financial incentive, most expressed recognition of their work and appreciation by the community as the most important motivational factor. Discussion: We found that the kaders are the main agents of health promotion and prevention services in the community and are responsible for community mobilization and Posyandu activities. However, more attention needs to be given to their role as agent of change that could be used as the prime link between the health system and the community.
Access to pediatric HIV care: Innovative public private partnership model to improve early infant diagnosis services in rural HIV clinics in Adamawa North East Nigeria.

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1 Management Sciences for Health

ABSTRACT

Background: In Nigeria, dried blood spot (DBS) sample collection and transportation to regional PCR labs for Early Infant Diagnosis (EID) of HIV has been a major challenge. Existing models are expensive and unsustainable. As a result, mothers waited for months to receive their infant's results. We evaluated the turnaround time (TAT) and cost of transporting DBS sample following the NIPOST implementation in Adamawa, North East Nigeria.

Method: To address these challenges, MSH partnered with the Nigerian Postal Service (NIPOST) to use the Expedited Mail Service (speedpost) in the transport of DBS samples from remote EID sites to regional PCR lab in July 2011-adapting the hub and spokes model whereby samples collected from PHC sites (spokes) are transported to secondary sites (hub), which in turn transport to the regional PCR laboratory. Orientation training, on basic facts about HIV, and safe handling of samples was conducted for NIPOST and facility staff. Rate of receipt of DBS samples, mean turnaround time (TAT) from DBS sample collection to delivery of test result to health facility and cost of transport of DBS samples were analyzed.

Results: Prior to this intervention, a little over half (51%) of the total DBS samples collected from these sites and transported by a designated courier company for analysis at regional labs were received. Within twelve months of this pilot, we observed a significant increase in the rate of receipt of DBS sample results, from 51% in July 2011 to 78% by June 2012. The mean turnaround time (TAT) had reduced from 90-120 days to 30 days. The cost of two-way transport of DBS samples reduced from US$69 to US$14 per shipment.

Conclusion: The NIPOST DBS transport model is a cost effective and sustainable model that can easily be scaled up, if we are to increase uptake of pediatric HIV services.
The impact of deploying paid community health workers on maternal, newborn, infant and childhood health and survival in Tanzania: the connect project

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ABSTRACT

Quasi-experimental studies of health interventions are rare, randomized cluster trials (RCT) of health systems interventions are rarer still. Yet RCT, are the most rigorous means of assessing the impact of health interventions. In 2011, the Ifakara Health Institute (IHI), the Tanzania Ministry of Health and Social Welfare, and Columbia University, launched 'Connect' as an RCT to test the maternal and child mortality impact of posting community health workers to communities for providing preventive, promotive, and curative antenatal, newborn, child, and reproductive health care. Mortality rates are observed in a disperse random sample of 50 intervention and 51 comparison villages where 400,000 rural villagers reside and where the IHI longitudinal Health and Demographic Surveillance System (HDSS) has functioned since 1999. This study compares intervention and comparison Connect endpoints 4 years prior to the RCT and 1.5 year after. We calculated under-five mortality rates and compared risk of death before age five between baseline and midline with Cox proportional hazards regression. Baseline childhood mortality was insignificantly different at the onset of the project (5q0 81.6/1,000 versus 81.7/1,000 (p=0.79). After 1.5 years of operation midline evaluation showed the post-infant mortality rates were 20% lower in intervention as compared to comparison areas (p=0.02) and the post-neonates mortality rates 7% lower (p=0.46). However, neonatal mortality rates were only 3% higher in intervention as compared to comparison areas (p=0.79). In overall, the under-five mortality rates were 9% lower in intervention as compared to comparison areas (p=0.16). Findings confirm that our RCT is robust and balanced. Connect is the most statistically rigorous trial ever to be fielded for testing the hypothesis that community-based primary health care workers can improve child survival and maternal health.
Integration of vertical programmes in response to community need: Integrating HIV testing into Kenyan community health systems

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ABSTRACT

Introduction The call for integration of HIV into other health services is strengthened by the current context of scale-up, sustainability and reduced donor funding. HIV programs in Kenya, an HIV endemic country, with 53% HIV positive individuals untested, are vertical, often run by non-governmental organizations. The Kenya community health strategy (CHS) defines service provision at household level and offers potential for such integration. We sought to identify opportunities and constraints for the integration of home-based HIV testing and counselling (HBTC) within the broader CHS to improve acceptability and performance of community based services. Methods We conducted a context analysis using qualitative research in peri-urban Nairobi and rural Kitui, exploring community and provider perceptions of integration. We carried out 40 in-depth interviews with policymakers, district and facility managers, and 10 focus group discussions with community health extension workers (CHEWs), community health workers (CHWs), HBTC providers and community members. We specifically asked about current practice and the need, willingness and concerns around HBTC service integration. Data was digitally recorded, translated, transcribed and coded in Nvivo10 prior to framework analysis. Results HBTC is offered in the community by NGO-employed HBTC lay counsellors as a vertical program that is not part of the current CHS. Policymakers expressed a strong desire to have CHWs trained to offer HBTC in households. There was enthusiasm and willingness among community members who stated that this would increase access to testing of men. Some concerns about stigma and confidentiality remained among all respondents who insisted that training on confidentiality was required. Discussion/Conclusion Our findings reveal community demand for integrated HBTC at household level that is endorsed by providers and policymakers and practical suggestions on how to overcome challenges in implementation, give potential for leveraging existing funding and expertise to meet community needs and national health priorities.
May I help you' - First step towards a people friendly public health facility: A case study from West Bengal, India

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ABSTRACT

Facilitation to patients and their grievance redressal is an important function in all health facilities. In absence of this, patients may be subjected to confusion due to lack of information, inability to avail several benefits that they are entitled to, leading to underutilization of services and quite often falling prey to exploitation from touts. However, this is a much-ignored aspect of hospital functioning in the public health facilities in India. In this context the West-Bengal Government first operationalized Rogi-Sahayata-Kendras (RSKs) [i.e. patient-health-centres] in 2008-09. RSKs have been set up at some District/Sub-divisional hospitals and Medical Colleges to assist the patients / attendants for ease and timely access of services at these hospitals. To scale-up this program; Department of Health, felt the need to assess functioning and outcomes of existing RSKs, and review the processes and challenges involved in implementation of RSKs. Therefore a rapid-evaluation was commissioned. The evaluation used qualitative methods for primary data collection. In-depth interviews were conducted with stake holders at state, district and facility levels, exit-interviews were conducted with a sample of inpatients and outpatients and group discussions were held with Rogi-Sahayaks (i.e. patient-facilitators) and Accredited-Social-Health-Activists (ASHAs). Secondary information in terms of guidelines, programmatic and financial data, and program registers and other relevant documents were reviewed. The evaluation addressed several questions like i) whether the RSKs were facilitating patients in accessing services and grievance redressal at the hospital in a convenient and hassle-free manner? ii) Whether the RSKs were being managed efficiently by the Hospital management and NGO partners? iii) Adequacy of financial arrangements between the hospitals and NGOs. On the basis of recommendations of this evaluation report, the State health department brought improvements in design, functioning and implementation system of this program. While the provisions for further scaling it up will be made in the coming financial year.
Hope and despair: Community health assistants’ experiences of working in a rural district in Zambia

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ABSTRACT

Background In order to address the challenges facing the community-based health workforce in Zambia, the government implemented the national community health assistant strategy in 2010. The strategy aims to address the challenges by creating a new group of workers called community health assistants (CHAs) and integrating them into the health system. This paper documents their motivation to become a CHA, their experiences of working in a rural district, and how the experiences affected motivation to work. Methods Data collected through in-depth interviews with CHAs in Kapiri Mposhi district, observations, and review of documents were analysed using a thematic analysis approach. Results Personal characteristics such as previous experience, passion to serve the community, and desire to improve skills motivated people to become CHAs. Health systems characteristics such as an inclusive work culture in some health posts motivated CHAs to work. Conversely, a non-inclusive work culture created a social structure which constrained CHAs to effectively conduct their duties. Further, limited supervision and misconceptions about CHA roles by some supervisors, as well as non and irregular payment of incentives also adversely affected CHAs ability to conduct duties. In addition, negative feedback from some colleagues at the health posts affected CHA's self-confidence and professional outlook. In the community, respect and support provided to CHAs by community members instilled a sense of recognition and belonging in CHAs which inspired them to work. However, the limited drug supplies and support from other community-based health workers inhibited CHAs ability to deliver services. Conclusions Programmes aimed at integrating community-based health workers into health systems should adequately consider multiple incentives, supervision processes and support from the district tailored towards enhancing the individual, health system and community characteristics that positively impact work motivation at the local level if such programmes are to effectively contribute towards improved primary health care.
Malaria and soil-transmitted helminthes co-infection in children in Cameroon: Impact of anthelmintic treatment on malaria transmission dynamic and immune response to malaria in three health district in Cameroon: preliminary results.

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ABSTRACT

Background Gastrointestinal nematode infections (GINi) are common in malaria endemic areas, particularly in sub-saharan Africa. Any relevant interaction between these parasites and malaria would be of considerable public health importance. Previous studies show that knowledge on this interaction is inadequate. The present study aimed at determining the effects of concomitant malaria and GINI on the anti-malarial total immunoglobulin Gamma level in school-aged children in Mfou, in the Centre Region of Cameroon. Methods Thick and thin blood smears were made from finger prick blood samples and examined for the presence of malaria parasites, parasites species and densities. Fresh stool samples were collected, processed and examined for gastrointestinal nematodes using the Kato Katz technique. Immunoglobulin gamma levels for three asexual stage recombinant antigens were measured by ELISA. Results Of the 503 children enrolled, 204 (40.56%) were malaria positive, while 148 (29.42%) harboured one or two gastrointestinal nematode infections. The majority of GINI was of light intensity infections. A total of 69 (33.82%) malaria positive had single or mixed co-infection with predominance of Plasmodium falciparum/Acaris lumbricoides. The majority of samples tested by ELISA, 66 (75%), were showed high titers of anti-malarial IgG antibodies. Mixed co-infected children had higher total IgG than those with simple co-infection. There was no statistically significant correlation between the levels of total IgG and presence of malaria infectionalone, GINI alone, and both malaria and GINI. Conclusion The findings showed that malaria/GINI co-infection does not affect the production of antimalarial total IgG in the children. However, further study is required to determine the effect of co-infection on antimalarial IgG subclasses. These results warn decision makers in the organization of community-based deworming and malaria treatment in children. Keywords: Malaria; Gastro-intestinal nematode infections; anti-malarial total IgG.
Are CHW programmes cost-effective? Insights from national programmes in Ethiopia, Kenya, and Indonesia

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ABSTRACT

Background Services delivered by community health worker (CHW) programmes may be more acceptable and accessible to local community members, however, evidence is lacking as to whether they represent good value for money. Following a review of the literature on costs and cost-effectiveness of CHWs, we developed a model to assess the cost-effectiveness of three national CHW programmes that differed in socio-demographic, epidemiological and health systems characteristics. Methods The study estimated the incremental cost-effectiveness ratio (ICER) of programmes from a government perspective. Programme costs were considered an incremental cost against a status quo of no CHW programme. For all three countries, incremental cost-effectiveness ratios (ICER) were expressed as incremental cost per life saved and per Life Year Gained (LYG). Results Confirming findings from the literature review, the three programmes modelled were found to range from highly to moderately cost-effective from a government perspective, with differences related to cost structures and to how effects were measured. However, the government perspective fails to capture important features, including societal and out-of-pocket costs that may impact significantly on cost-effectiveness. Further, in all three settings, CHWs do not work alone, but are embedded in wider systems for delivery of health care; they operate within teams, work alongside community-based volunteers, and are supervised by district staff. Conclusions The social, political, and policy contexts within which the three CHW programmes are operating are evolving. CHW programme effectiveness is ultimately determined by the mix of CHW programme design features and the context within which CHWs operate. Further research focused on incremental costs and effects of components such as training length and supervision would significantly aid in understanding how to shape, expand, and scale up CHW programmes. As many issues are not readily quantifiable, mixed method approaches will be most useful.
Community and district empowerment for scale-up CODESA pragmatic RCT to evaluate evidence based planning and social accountability in Uganda

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ABSTRACT

Background: Although highly effective and affordable child survival interventions are well known, a considerable ‘know-do gap’ exists in low-income countries. The district level is the key implementation level. Lack of data and analytic capacity may preclude prioritization of interventions in national child survival packaged in the local context, and management weaknesses impede implementation. Such 'supply-side' weaknesses compounded by poor 'demand' on the community side contribute to low coverage and quality of efficacious interventions and practices. We hypothesize that prioritization based on district epidemiologic profiles and bottleneck analysis, combined with quality improvement interventions, and appropriate community monitoring/social accountability will lead to accelerated scale up of key protective, preventive and curative interventions against under-five mortality, compared to standard planning procedures. The Community and District Empowerment for Scale up (CODES) intervention has three objectives: To (1) analyze the causes of bottlenecks hindering the scale up of the locally prioritized child survival interventions and provides districts specific solutions to improve coverage, (2) build capacity among the local management teams to develop and implement context-specific solutions, (3) foster community monitoring and social accountability for improved service delivery and increased demand. Methods: A first learning phase in 5 districts to optimize the intervention has been concluded, and is now followed by a controlled process, cost and effectiveness evaluation randomizing 16 districts to receive CODES- or usual Ministry of Health- guided implementation of the national package of child survival interventions. Result&Discussion: First results will be presented. Core to this intervention is implementing and planning evidence-based child survival strategies based on a priorities identified through bottleneck analysis using locally generated data on both the supply (health facility) and on the demand (community) side, overseen by community monitoring and facilitated dialogue with service providers. Methods to strengthen district-level managerial capacities and community monitoring will have implications beyond Uganda.
The role of veto points in the adoption of universal health coverage in Turkey

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ABSTRACT

Background: Why did Turkey's Health Transformation Programme (HTP) reforms result in a unified universal health coverage (UHC) system, while in other middle-income countries these policies have not been fully realized? How did the institutions involved in making policy decisions structure the health policy-making process in Turkey between 2003 and 2012? This paper uses the theory of institutional veto points to analyze the legislative and administrative processes involved in creating both a unified financing system and unified public hospital system as part of the overall effort to achieve UHC. Methods: This qualitative case study research analyzes extensive primary interview data collected to examine the process to adopt UHC in Turkey. First, it lays out the institutional veto points involved in making primary, secondary and tertiary level policy decisions in Turkey. Second, it analyzes the Minister of Health's varied use of legislative and administrative instruments to move towards a unified UHC system in Turkey. Results: I show that the Minister of Health devised legislative strategies based on the structure of institutional veto points and the political actors involved in the decision-making process. His staged approach to the policy adoption process allowed the Minister of Health to employ different strategies for different aspects of the overall reform. Discussion/Conclusions: This analysis shows how institutional veto points determined the Minister of Health's policy adoption strategies to unify health financing systems and public hospital systems in Turkey. By taking a staged approach and strategically choosing different types of policy instruments, the Minister of Health was able to effectively achieve his policy objectives, despite opposition by important political actors. This research provides an important example for other countries that are seeking to adopt policies to achieve a unified UHC system and other potentially controversial health reforms.
Public Private Partnership in the health sector in Cameroon: A case study of staff secondment into the Maroua-Mokolo Diocese.

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ABSTRACT

Background: Public private partnership (PPP) between governments and faith-based health providers has recently been strengthened in several African countries, including Cameroon. Cameroon is considered to have a weak health system because of limited public service provision and access. In this case, PPP includes the arranged secondment of government-employed health workers into Catholic health facilities. Little is yet known about how this policy impacts on the Catholic system, or the broader national health system. Methods: This paper reports on a case study of the staff secondment policy and implementation in Cameroon. It is a sub-study to a three-country case study which focuses on maternal health services by Catholic providers. Data from 30 semi-structured interviews conducted with health workers and managers at three medical facilities from one region in Cameroon was considered. Utilizing thematic analysis, these three facility sites were compared, also drawing on observation data as well as primary and secondary literature. Results: It was found that Catholic health managers emphasize a participatory management approach. They saw the seconded staff as a potential threat to this management approach, and to the Catholic organizational culture more broadly. Other issues such as patient reception, health worker motivation strategies and geographic placement of staff were prioritized. Discussion: In Cameroon, staff secondment was perceived as a useful systems strengthening intervention. In Ghana, the policy has been adapted, in that the government now funds the salaries of staff that are employed and managed by the faith-based providers. In Cameroon, several barriers are seen to the effective implementation of this systems intervention - in particular the clash between organizational cultures and management practices. Individual health worker's values also needed to be carefully considered. Better selection and orientation processes, and a greater level of management control being given to the direct line managers can mitigate barriers.
Mobility of health staffs during conflict and post-conflict situations in a decentralized system, a case study of Northern Uganda

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ABSTRACT

Introduction Decentralization is the established policy for recruitment and deployment of health staffs in Uganda. How this policy was implemented during conflict in northern Uganda has not been systematically documented. The aim of this study was to describe how health workers have changed jobs over the conflict and post-conflict period in order to understand how the policy of recruitment and deployment under decentralization was implemented or not. Method This study was conducted in three northern districts of Uganda. A qualitative study design was used. Job histories with health workers who have served over the conflict and post conflict period were conducted. Questions were related to the different jobs that health staffs have served in. In-Depth Interviews with central government officers, health managers at the district level and Key Informant Interviews with district leaders were included to triangulate our data. Results During the conflict, recruitment and deployment components of decentralization could not be applied. Health managers in the public services adopted adhoc mechanisms to staff rural health centres. Public health systems were in competition for health staffs with the non-governmental organisations. Mobility of health staff tended towards non-governmental organisations that had a more robust recruitment mechanism. After conflict, the policy for recruitment and deployment was re instituted and health staffs tended to shift to the public service creating apparent shortages of health staffs in rural posts. Discussion/Conclusion Mobility of health staffs during the conflict in northern Uganda was partly influenced by failures to implement the established policy of decentralization to recruit and deploy health staffs. During conflicts, central governments should institute tailored approaches to recruitment and deployment policies and implementation in order to continue staffing decentralized rural areas. Coordination between public and non-governmental organizations early in the conflict can help to mitigate the problem of rural staffing.
Perception of health system and community on a multi-faceted health system strengthening intervention in Dharmapuri, Tamilnadu

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ABSTRACT

Background: Communitisation is a term widely used in India to enable community towards ownership and managing health services and institutions through participating in planning, monitoring, promotion activities to improve community health. This led to strengthening of health system through improving governance and accountability. Implementation and research experiences of Community Action for Health (CAH) (described earlier in Beijing HSR) to strengthen village health committees for health action, showed diverse perceptions among Health System and Community towards process, outcomes and values. This study focused on exploring the perception and experiences on communitisation among health system actors and community through implementation of CAH. Methodology: This exploratory study collected qualitative data on communitisation. Framework analysis using applied policy research was done. Findings: All respondents felt accountability and transparency in health system, would improve people’s trust on health system. Community felt poverty, dependence on daily wages, lack of awareness on health rights and programs limited their capacity to demand better health services. Community also expressed that health system staff should devote time for village services and be accountable for their performance. Though frontline workers agreed need for greater accountability they blamed communities for not accessing services being provided. They also cited task over burden and lack of coordination between social sectors as critical constraints. Community monitoring process improved community awareness, participation and empowered to attain health rights. Accepting accountability strengthening measures and community monitoring was challenging initially among health system personnel resenting as NGO nature. However their perception changed, as it strengthened public health system through increasing community demand, thus enabling frontline health staff to reach targets. Conclusion: With varied perception and systemic constraints in implementation, communitisation should be recognized as long term social process requiring change of culture in community participation and tenacious health system commitment to transform CAH to sustainable community led process. This research would contribute significantly towards health system strengthening efforts as it emerged based on implementation requirements.
Strengthening district health information management using a quality improvement approach in KwaZulu-Natal, South Africa.

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ABSTRACT

Background South Africa has implemented a district health system with the aim of delivering accessible, equitable, efficient and sustainable health service, however, the quality of data remains a key concern. In response to findings from the auditor general's office, KwaZulu-Natal has implemented a strategy to improve data management. MatCH (Maternal, Adolescent and Child Health), has a PEPFAR-funded health systems strengthening project in two districts in KwaZulu-Natal focusing on the 6 WHO building blocks. MatCH is working closing with the provincial health department to build monitoring and evaluation capacity at district and facility level. Methods A quality improvement plan was drafted in August 2013. MatCH seconded two staff to the province to conduct data audits using a standardised tool to review policy, data collection tools, monthly data sign-off, record keeping, governance and security. The team visits a sample of facilities in each district and conduct audits in collaboration with facility staff. Quality improvement plans are drafted based on findings. Trainings on policy and monitoring and evaluation basics are provided to facility managers. Results The team has conducted 11 audits in 5 districts. Key challenges include data not matching source documents, missing or incomplete tally sheets or registers and use of non-standard tools. Best practices included regular information meetings on site, routine internal audit processes and data sign-off records. Quality improvement plans were drafted to address weaknesses and follow up assessments were planned. Training has improved the utilisation of data and the institutionalisation of data quality assurance. Conclusion The use of a standard audit tool has highlighted key gaps in data management. Quality improvement plans have been implemented and follow up visits have found improvements. Involving facility staff in the process builds capacity in data management and improves ownership of data management processes.
Building local ownership of decision making in human resource management: lessons from three districts in Uganda

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ABSTRACT

Background: In addition to staff shortages, Uganda faces health workforce performance problems. Decentralised management structures offer district health management teams (DHMTs) greater decision-making opportunities, including in human resource management (HRM). The PERFORM project investigates how a management strengthening intervention in the form of Action Research (to identify problems and their root causes, plan, act, observe, reflect and re-plan) can be used to build DHMT capacity and ownership for the design and implementation of HRM strategies to improve health workforce performance. Effective facilitation by researchers is key to the success of the Action Research approach. Methods: In a series of workshops and review meetings, researchers facilitate three DHMTs to strengthen their management approach to improve the performance of the health workforce through the Action Research cycle. The PERFORM project documents observations and reflections as part of the research. Results: Facilitated workshops where DHMTs came together, created collaborative and creative spaces for developing appropriate and innovative strategies for improving workforce performance for inclusion in district plans. Reflective practice was encouraged through DHMT diaries, to explore how and why key decisions were made, and the implementation of the strategies. Dialogue between DHMTs is fostered in many forms including Facebook pages to share good practice and learning, electronic newsletters and periodic face to face meetings and workshops. Learning from and adapting promising practices from different districts supports innovation, for example the facility management team in one district supported staff appraisal and this will potentially be adapted in another district which has a challenge with absenteeism. Conclusions: Our research has shown that the Action Research approach using facilitated workshops, review meetings and communications can empower DHMTs to develop locally appropriate solutions to their health workforce problems. Some DHMTs have also reported using this approach for addressing other management problems.
Improving primary health care through community participation

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ABSTRACT

BACKGROUND Community participation is a key tenet in the primary health care approach. Research has shown that community participation can improve health services and outcomes, and ensure a more responsive and equitable health system. South Africa is currently reforming its health system through the introduction of a National Health Insurance (NHI) and the re-engineering of the primary health care system. The aim of this paper is to discuss how community participation can become a valuable component of a people-centred primary health care. METHODS The paper presents research on the role of health committees in Cape Town. A mixed methods design includes a survey, in-depth interviews and participant observations. Health committees' description of their role is analysed according to two categories: community involvement and community participation. Community participation is defined as active engagement in identifying problems, finding solutions and taking part in decision-making. In contrast, community involvement is defined as community members supporting the health system in a voluntary capacity through carrying out tasks defined by the health facility. An appraisal of policies relevant to community participation is used to assess whether the current policy context is conducive to meaningful community participation. RESULTS It was found that health committees' role is primarily involvement rather than participation. Their limited participation is linked to lack of clarity on their role and to a policy vacuum. It is argued that the NHI does not provide a policy framework for meaningful participation because it does not take cognisance of current structures for community participation such as health committees. Furthermore, it is incongruent with a national draft policy on health governance structures and its conceptualisation of community participation resembles community involvement. CONCLUSION The paper concludes that the NHI needs to clarify the notion of community participation and health committees role in the re-engineering of primary health.
Measuring district health system capacity: A key step in the implementation of a district-based programming strategy for HIV care and treatment services in Uganda

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ABSTRACT

Background: Aligning with Uganda's Ministry of Health strategic plan, CDC-Uganda has adopted a district-based programming strategy to provide comprehensive HIV prevention, care, and treatment services. Efforts therefore focus on strengthening district capacity, institutions, and systems to deliver effective and efficient health services for sustained high-quality impact over time. A key step in ensuring the success of this approach is to routinely assess district capacity to provide HIV care and treatment services. This paper highlights tools and a methodology developed for routine monitoring of district capacity to provide HIV care and treatment services in Uganda. Methods: The tools developed and piloted in 6 districts in Uganda covered capacity outcome indicators measuring district health system capacity in selected key domains, transition benchmarking indicators to assess the level of involvement of the District Health Team and the PEPFAR-funded Implementing partner (IP) supporting the district in each of those domains. To complete the assessment, data from facilities were collected using interviews, reports and other documentation available at district health offices, supplemented by qualitative information elicited through unstructured clarifying questions. Results: The results highlighted health system domains for which the district was primarily responsible, and others where the IP provided critical support to the district as well as domains where districts had limited capacity and needed continued support. The tools also measured the level of technical assistance provided by IPs in relation to district needs. Conclusion: District summary reports and a dashboard act as useful guides to identify key areas for capacity building of the district health system. They form the basis for action planning meetings for IPs and districts on a regular basis as they continue to strengthen district capacity and the institution of the District Operational Plan to provide high quality HIV care and treatment in the context of decentralization.
Challenges to recording and reporting of uptake of Intermittent Preventive Treatment in pregnancy (IPTp) at facility level in Uganda: supply-side views and records review

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ABSTRACT

Background: Malaria infection during pregnancy poses substantial risks to mother and child. The World Health Organization recommends intermittent preventive treatment in pregnancy (IPTp) with sulfadoxine-pyrimethamine, delivered as part of focused antenatal care (ANC), in areas with moderate to high malaria transmission in Africa. In many countries IPTp coverage appears to be low despite high ANC attendance figures. It has been noted, however, that recording and reporting systems are often weak and available data may be inaccurate. In order to strategically tailor interventions to the needs of pregnant women in different local contexts, policy-makers need access to reliable and accurate routine data from health facilities, allowing them to continuously assess progress and performance based on up-to-date information. Methods: Accuracy and reliability of data relating to IPTp and ANC at facility level were assessed through a review of data recorded at and reported by four health facilities in Eastern and West Nile regions, Uganda, and data management issues explored through 18 in-depth interviews with health care providers and district-level officials. Results: Comparing data from facilities ANC registers with figures reported by the same facilities to the district level showed both over and under-reporting with regard to ANC attendance and IPTp coverage. Misreporting appears particularly pronounced for provision of second dose of IPTp and in higher-level facilities. Observation of data recording practices and in-depth interviews identified a range of factors limiting data validity, including workload, attitude and skills of ANC staff, lack of quality assurance and reporting forms, inflexible data entry format and inadequate coverage indicators. Conclusion: The study highlights considerable challenges in data recording and reporting at facility-level, which is likely to limit policy-makers ability to adopt strategic and locally appropriate approaches based on robust and accurate evidence. In order to improve IPTp uptake, greater investment in data management is essential.
Health sector priority setting at meso-level in lower and middle income countries: Available options and suggested steps to ensure population accountability, efficiency and effectiveness

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ABSTRACT

Background: Setting priority for health programming and budget allocation is important for accountability and efficiency, but there is little consensus on related processes. It is particularly relevant in low resource settings and at province- and district- or ‘meso-level’, where contextual influences may be greater, information scarce and capacity lower, especially in decentralised nations. Nonetheless, the literature is relatively silent on evidence-based priority-setting in low and middle income countries (LMICs), especially at meso-level, and the priority-setting processes (PSPs) piloted or suggested there. We assessed the evidence on PSPs according to the participation and influence of various stakeholders, and the influence of different PSPs on resource allocation and outcomes. Method: An exhaustive search of the peer-reviewed and grey literature published in the last decade, yielding 57 background articles and 75 reports related to priority-setting at meso-level in LMICs. Results: We conclude that no currently documented process can be confidently recommended for such settings. Although proponents of certain PSPs advocate their use, problems with stakeholder representation, inexperience, availability of data/information, funding flows and vested interests are common. Accordingly, other experts instead suggest broader elements to ensure propriety, feasibility, fairness and local relevance in priority-setting. Common reasons for failure at all levels suggested that local authorities should additionally consider contextual and systems limitations that may prevent a satisfactory process and outcomes. Recent literature proposes a list of related attributes and warning signs, enabling preparation of a simple decision-tree to help determine whether or not health systems issues should also be improved alongside support for needed priority-setting; what elements need improving; monitoring, and evaluation. Discussion: Health priority-setting at meso-level in LMICs may involve common processes to ensure stakeholder representation, but will often require additional attention to local health systems to improve population accountability, efficiency and effectiveness.
Social accountability mechanisms in maternal health services: situational analysis in Muanda and Bolenge health zones, Democratic Republic of Congo (DRC).

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ABSTRACT

Background Maternal mortality, with 549 as ratio, remains high in the DRC. Innovative strategies are needed, such as social accountability (SA) to improve service delivery. SA is the mobilization of communities to voice their concerns and assert their rights to accessible health services so as to improve responsiveness. This study explores existing SA mechanisms through which interests of women were expressed and responded to by health providers (HP). Methodology A situational analysis was conducted in 2 DRC health zones (HZ). Data on ways to express and enforce responses to women's concerns, and perceived responsiveness by HP were collected using semi-structured interviews. Were purposively sampled 25 women, 5 men, 5 HP, 2 HZ officers and 11 community stakeholders. The Atlas-ti 6.1 software helped to analyze data using both inductive and deductive approaches. Realist approach was used to gain insight in what works, for whom, and under what circumstances. Findings. Women raised very few concerns about health services and did not use to report them. This was related to the absence of procedures to voice, or the lack of knowledge thereof, to the fear of reprisals or to be misunderstood. Women preferred individual means rather than collective, exposing them to reprisals. Instead they looked for intermediaries, mostly, trusted HP, community health workers (CHW), local authorities and leaders. HP perceived themselves as being relatively responsive to population's concerns and used CHW or home visits to get information from women. They informed the community through health committees but did not provide information about health services performance. There was no means to sanction HP in case of inappropriate practices, rewarding was mostly done individually through presents and compliments. Conclusion. Social accountability is relatively inexistent in DRC maternal health services and efforts have to be made to create spaces where the powerful are enabled to be more receptive to the demands of the powerless.
A study of performance dimensions in public hospitals in India

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ABSTRACT

A STUDY OF PERFORMANCE DIMENSIONS IN PUBLIC HOSPITALS IN INDIA  Background: Even as governments in India are increasing financial support to public hospitals and large numbers of rural and poor people thronging these institutions, there is hardly any study on the performances of these hospitals. More so, very few studies have focussed on the physicians’ perspectives, who are the key decision makers in hospitals. This study is on the physicians’ perspectives on the identified 90 performance attributes from 482 practicing physicians in the states of Tamil Nadu and Kerala to understand what internal factors contributed to better clinical and physicians’ outcomes. Methodology & Data Analysis: The study was exploratory in nature. The sampling frame consisted of physicians working on the payroll of Directorate of Health Services in these two states. A purposive sampling was done to keep those with a minimum of two years experience in the sample. A rating scale based on Likert’s scale was developed and administered to physicians. The reliability of the scale was tested using Cronbach’s alpha. The research model was validated through a Structural Equation Model (SEM). Finally, importance performance analysis (IPA) was conducted on the physicians’ perceptions to identify areas that are important but not attended to. Findings & Summary: There was a strong relationship between the internal dimensions and clinical outcomes ($R^2=0.73$) and physician outcomes ($R^2=0.67$). Patient focus & process focus had significant impact on clinical outcomes. While reduction in mortality, increased inward referrals, decreased outward referrals, improvement in the image of the hospital are seen as better clinical results. The importance performance analysis identified 15 areas for immediate intervention. The study highlighted the importance to develop standard treatment protocols, financial autonomy, leadership training, recognizing physicians’ contributions besides a patient centered approach as factors leading to better performance of public hospitals.
The research of president occupation in China county hospitals by PEST analysis

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ABSTRACT

Background: In China, 60% of the population in rural areas. Improving the county hospital medical technique and service ability is the key to the Reform of Public Hospitals. And the quality and level of the hospital management directly affect the survival and development of hospital. Documents about Comprehensive Reform of County-level Hospitals clearly put forward, to establish the president responsibility system. Therefore, to explore the status of hospital management and the occupation development strategy has the important practical significance and theoretical value. Methods: (1) Questionnaire survey 203 senior managers from 35 county-level hospitals in 26 provinces. (2) Analysis of the external influencing factors by PEST, and then put forward some improvement measures. 'Political Factors, Economic Factors, Social Factors, Technological Factors' Results: (1) Lots of president of county-level hospitals chose from the clinical doctors, professional degree is only 12.8%. (2) Lots of County hospital president (86%) urged to promote the specialization of occupation; they think, County hospital leadership management system needs to be improved, including the selection, appointment, evaluation, salary, reward and punishment. (3) Promoting the county hospital professional depends on Some of management system and health policy. We should make use of favorable conditions, to overcome the disadvantage factors. Discussion: (1) The government should strengthen the professional training of the county hospital leadership, strengthening the work of scientific management consciousness, improving the professional quality. (2) During the process of promoting the county hospital comprehensive reform, the government should openly choose the county hospital director, and make clear work objectives and evaluation mechanism of tenure. (3) The government should set up the hospital management title series, different salary levels respectively, creating the title promotion path and prospect broad occupation as interested in hospital management personnel.
Weaknesses and opportunities of routine health information system in Bangladesh

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ABSTRACT

Effective routine Health Information System (HIS) is a key health system building block which enables decision makers at all levels to identify gaps, monitoring progress, make evidence-based decisions, and efficiently distribute resources. However, routine HIS for improved health system in developing countries has been a consistent problem. Bangladesh has also been experiencing a weak HIS which was recommended to be strengthened in various technical reports. International Centre for Diarrhoeal Disease Research, Bangladesh undertook a comprehensive assessment of the government's existing routine HIS from community up to the district level to identify gaps and opportunities. During assessment at the local level in three districts, we interviewed managers, MIS personnel, and service providers; observed data collection and reporting process; collected MIS tools. At the national level, meetings with relevant government and non-government organizations were also done to get a holistic picture. The comprehensive assessment identified a number of weaknesses in the existing routine HIS: overburdening of service providers with redundant and unstructured paper-based MIS tools; lack of reliable routine data, particularly denominators; multilevel compilation of facility and population data; fragmentation of systems within and between directorates; inadequate access and use of routine data for local level planning; poor monitoring and feedback mechanism. The assessment also found a number of opportunities: precise obligation in current sector-wide programme known as HPNSDP (2011-2016) on strengthening routine HIS; strong leadership of MIS directors; support from highest level policy makers (i.e the ministry); adequate willingness among policy makers regarding importance of routine data; establishment of State-Of-Art ICT infrastructure at the national level to support the strengthening process; tangible interest among multiple national and international organization. A well coordinated, comprehensive, participatory, and within-the-means efforts are needed for maximum utilization of the opportunities to address the gaps in existing routine HIS of Bangladesh.
Access to medicines against CNCDs in Cameroon: Stakeholders perspectives on access to pharmaceutical information within mixed markets

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ABSTRACT

Background: In most sub Saharan health systems, while infectious diseases are top priorities backed by global health initiatives, patients suffering from CNCDs mostly cope with the mixed health systems in which the private sub sector dictates its market rule. Hypothesizing that an Observatory of Medicines against CNCDs tailored to disseminate targeted information to stakeholders would enhance access to medicines, we are implementing a three-year grant and this is the second out of three linked abstracts whose objective is to analyze the views and perspectives of stakeholders on access to pharmaceutical information. Methods: We conducted a multiple methods situational analysis study including a scoping document review, a knowledge attitudes practices and preferences survey of prescribers, dispensers and patients suffering from hypertension, diabetes, breast cancer and prostate cancer, in-depth interviews with decision makers nationwide in Cameroon and, a focus group discussion with journalists. Quantitative data related to household incomes and drug prices were analyzed to depict inequalities. Qualitative data were analyzed to describe barriers, stakeholders views and perspectives on access to pharmaceutical information and systemic consequences in terms of access and use of medicines. Results: We will exhibit the stakeholders views and perspectives on financial accessibility of medicines, on systemic consequences of poor access to pharmaceutical information. Economic analysis illustrates the privatized medicines market. The monthly average bill for medicines against CNCDs varies from 36 to 116 Euros and medicines against hypertension and diabetes cost respectively from 1 to 23 and 40 Euros (40% of the population live with less than 42 Euros monthly). Discussion: Under a systemic perspective, in a country with a health insurance coverage rate below 2%, medicines market mostly operates under private rules. Lessons learnt from this pilot study should inform future research on pharmaceutical information systems in similar contexts. Reinforcing the pharmaceutical information systems to promote equitable access to tailored information for patients potentially equates enhancing equitable access to medicines against CNCDs.
Persisting high levels of child undernutrition in India -
Understanding the equation between accountability and
people’s voice power

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ABSTRACT

Background: India is home to 40% of the world’s malnourished children with no significant decline over last fifteen years. Accountability is a concept often referred to but mostly evasive and difficult to measure. Methodology: The three domains of accountability - financial, performance and social - of the flagship Integrated Child Development Services (ICDS) scheme under Ministry of Women and Child Development (MWCD) program were assessed. Secondary data from policy and strategy documents, union budgets, and annual and evaluation reports for the last ten years was analysed. Results: After years of ambiguity in roles of MWCD and Ministry of Health and Family Welfare, MWCD defined clear targets for reducing undernutrition in XII Five Year Plan (FYP) 2012-2017. The budget allocation increased nearly threefold from $72 billion in XI FYP to $200 billion during XII FYP. In the first year of XII FYP (2012-13), of the planned $27 billion, $25.7 billion (94%) was allocated and $23.6 billion (92%) was released to states. A Public Interest Litigation resulted in 2001 Supreme Court order for universalisation of ICDS scheme. At the end of X FYP (2007) there were 844,743 anganwadi centres AWCs (60.3%) and increased to 1,304,611 (93.2%) in XI FYP (2012). The Evaluation Report (2011) reported 67% coverage of eligible children by the existing AWCs. The MWCD drafted the Citizen’s Charter in 2011 and defined processes for monitoring, grievance redressal, social audit and public hearings in the ICDS framework document (2012). The institutional mechanisms for social accountability such as proactive disclosure of expenditures at all levels, community score cards, citizen based vigilance - are yet to be put in place. Discussion: In the absence of any imposition of sanctions for failure to deliver services and ‘spaces’ created for citizen voices, the major changes have been an effort to comply with judicial orders initiated by citizens.
Decentralized health systems and decision-making space in Tanzania: opportunities and challenges

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ABSTRACT

Background Tanzania has since early 1990s been implementing decentralization in the health sector. Decentralised management can make local health systems more responsive to local needs by recognising people's voices in planning and management decisions. Using Bossert's 'decision-space' framework, which defines decentralization in terms of the set of functions and degrees of choice that are transferred to local government officials, the presentation will highlight the reality of local decision-making space under decentralized management in Tanzania. Methods The study was conducted in three districts in Tanzania. We used qualitative approach to identify the views of the Council Health Management Teams (CHMTs) through in-depth interviews and focus group discussions. These views were captured using CHMTs self-assessment tool structured around key areas of district-level management decisions and analysed using 'decision-space' framework. Findings The decision space of the CHMTs was self-perceived to be wide in a number of human resource management domains such as hiring and firing of specific personnel; contracting staff with locally generated resources; establishing incentive schemes; appraisal of staff performance; and supervise health facilities. However, in a few areas the decision space was narrow, such as: setting job description and establishing information system. Nevertheless, it appears that the CHMTs in the study districts have limited capacity to identify and utilize the decision-making space. There were differences in degree of decision space across the districts particularly, in organizing and financing continuing education, establishing incentive schemes and setting health policies locally. These may be attributed to different understandings of the CHMTs about the concept of decision space. Conclusion Decentralization has provided some decision-making space for the CHMTs to improve health service management. Better utilisation of this space would likely improve responsiveness of local health systems. The CHMTs may need external support to make better use of the available opportunities and address challenges.
Unearthing the mechanisms behind the public accountability practices of district health management teams: a realist inquiry in two local health systems in Ghana

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ABSTRACT

Background: District health management teams could play an important role in democratizing decision-making and bolstering accountability towards the public. This entails a re-visioning of their role and responsibilities. Significance field-building dimension: In local health systems in LMIC, district health management teams, together with local authorities, bear the responsibility for health sector performance, for which they are accountable towards the population. This explorative study appraised actual public accountability practices of district health management teams in two local health systems and explored how these could be improved.

Methods: Comparative case study design based on realist inquiry. An initial middle range theory was developed on the basis of a literature review of governance and accountability spanning different social science research traditions. It was tested in one urban and one rural health system. Data collection included in-depth interviews, and review of reports and routine data. Results: In both districts, health management teams had strong upward accountability systems, enforced by command-and-control mechanisms. In the rural local health system, the district health management team had strong horizontal accountability practices towards the District Assembly and INGOs involved in health service delivery. These were based on reciprocity. However, in both sites, public accountability strategies or processes were found to be virtually absent. None of the district health management teams achieved full public accountability. Procedures to enforce accountability towards the public were found to be absent and channels for effective involvement of the public weak. Conclusion: The study resulted in a refined middle-range theory that points to the critical need for enforcement of accountability practices by a meta-governor and remedial action in case of public accountability gaps. Local authorities and District Health Management Teams can play this role, for which they need skills, resources and decision spaces, but critical is a clear and well enforced mandate and effective channels for the public to exert pressure.
Understanding health decision-making in Pakistan from organizational, strategic and political economy lenses

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ABSTRACT

Background Considerable investments and reforms prescriptions have failed to improve health indicators in many developing countries. Political economic considerations - personal motives that run contrary to public good - limit the efficacy of health systems. We studied decision making processes in health in Pakistan.

Methods Our study explored decision-making from political economic, organization and strategic lenses using qualitative interviews and a desk-review of health and population policies. Results Institutional mandates are seldom recognized or used to devise policy or programs. Top political leadership originates most new ideas, based on personal agendas, donors, or political expediency, favoring 'headline' projects i.e. constructing hospitals or providing jobs to potential voters, to garner votes. Having unpredictable and short tenures (average: 4-7 months), senior bureaucrats follow politicians' agenda for job security. Mid-level officials often stay in their positions for most of their career, follow 'authority' orders and maintain status quo. Since arbitrary standards determine officials' performance, recruitment, promotion and transfers, individuals seldom take initiative without 'consensus' among their colleagues; leading to inaction, obviating initiatives or reforms. Formal systems are lacking for gathering and processing information, institutional memory or promoting experiential learning/ avoiding previous mistakes, in part due to the absence of engagement with academic institutions. The system neither rewards nor even measure performance in terms of outcomes. Policy targets, budget allocations and achievements are seldom related. Donors most often follow evidence for decisions making. However in 'urgency to move resource', country level personnel follow their institutional priorities and sometimes ignore evidence that runs contrary to these priorities. Conclusions Any strategies used are personal/ ad hoc rather than institutional. Public actors are insulated from feedback of the public - the eventual beneficiaries of public health programs - which limits performance of the health system by allowing private interests of health system actors over public goods.
Grant-making foundations for global health: what drives their decision-making?

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ABSTRACT

Private philanthropic foundations are increasingly present in the academic and non-academic debate for their relevance in global health funding and their influence in policy-making. Their role has recently put them under increasing pressure to be both effective and legitimate actors in global health, opening concerns on their relevance in influencing the health research agenda and the correlated responsibility and accountability practices. Despite this, almost nothing is known about how these actors make decisions on their priority-setting and grant-making. This question is relevant for health systems as recipients of foundations' grants, recognizing that the decisions which contribute to determine health systems' performance are made by people across all parts of the global health arena's including the private no-profit sector, such as foundations. The aim of this research is to understand which factors influence foundations' decision-making. The specific objectives are reflected in the areas of inquiry of the framework proposed, aiming at exploring the relationship between foundations and their external environment on one side (grantees, partners, other global health policy actors) and their internal agendas and constraints on the other (missions, governance structures, processes and leadership roles). This research applies a multiple case study design based on three foundations: the Gates Foundation, the Rockefeller Foundation and the Wellcome Trust. Semi-structured interviews with 46 foundations' respondents represented the main method for data collection. Results show that foundations' decisions are heavily influenced by the struggle to get recognition in the global health field, the weight of their leaders in their prioritization as well as grant-making processes, and the role of different institutional settings. This can be useful for both foundations themselves and global health policy-makers, in view of the current debate around philanthrocapitalists and their impact on global health.
Legitimation of health goals in the post-millennium development goals agenda-setting process

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ABSTRACT

Purpose: The paper seeks to discuss health governance and political prioritisation in relation to the United Nations (UN) new global development goals, intended to succeed the Millennium Development Goals (MDGs) that expire in 2015. Focus/content: The paper analyses the consultations on the 'post-2015' agenda with special focus on politics of legitimation in relation to health goals to be included in the new development agenda. In the 'post-2015' consultations, ambitions to create a participatory process and broad agenda ownership feature prominently, as do contestation on what development goals are to be promoted. UN agencies, governments, civil society, academia, business actors and others have so far participated in the process. The theoretical framework highlights three main elements that may affect the legitimation processes: sources of legitimacy, audiences of legitimation and kinds of legitimation. The analysis points to the political character of legitimation processes and what should be included in the future development agenda, particularly in issue areas deeply influenced by global inequalities. It also shows that despite UN ambitions to create an inclusive process, so far legitimation is shaped by the institutional preconditions of decision-making, turning states of the UN General Assembly into the ultimate audiences of legitimation efforts. Significance: The new goals will provide political guidance for commitments and resource allocation in the realm of development between 2015-2030, including development assistance for health and the strengthening of people-centred health systems. The long-term character of the new development agenda implies that issues pertaining to its legitimacy, or lack thereof, will remain central for many years as legitimacy can be expected to impact the governance and implementation of the new goals. Yet, there is a lack of studies with a legitimation perspective on the 'post-2015' development agenda-setting process.
The central role of identity in shaping leadership and management practice: experiences of PHC facility managers in Mitchells Plain, Cape Town, South Africa

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ABSTRACT

As recognised within global health system debates, leadership across health system-levels is critical for sustained performance improvements. However, leadership is rarely the focus of health system research. Despite their important role, surprisingly little is known about the managers of primary-level facilities, the dimensions of their job, the challenges they face, what influences the way they practice management and how better to support them to manage effectively. This paper reports an in-depth qualitative exploration of the experiences of such managers from Cape Town, South Africa. The overall purpose was to contribute to wider thinking about how better to support leadership development at the primary healthcare-level. Adopting case study methodology, the primary researcher engaged with eight facility managers from one geographical area. As is common in Africa, these managers were all nurses by training. The managers reflected on their life and work through life history interviews, and discussion of critical managerial incidents recorded in personal diaries, and the researcher also observed them at work and explored with them other colleagues' perceptions about their leadership. Our work was founded on the conceptual understanding that identity transformation is central to leadership development. We found that facility managers who develop a managerial-identity appear better positioned to manage themselves, their staff and facilities more effectively than those who retain a dominant nursing-identity, preferring clinical over managerial duties. Clinical nurse training does not well prepare managers for their managerial tasks, and little support is currently provided to nurses in their transition to managers. Our findings suggest that such support might encompass nurturing nurses with managerial ambitions, induction and peer mentoring for newly appointed managers, on-going peer-support once in post and continuous reflective practice. As one of the first such studies, these findings contribute to theory building about the practice and development of health sector leadership, informing future research.
Fresh starts: How new districts use community participation to build their programs

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ABSTRACT

Introduction: In Uganda, district splitting led to the creation of 58 new districts between 2005 and 2010. New districts face challenges of having to create new administration and infrastructure. Fresh starts also open opportunities for new leaders to be open to more people centeredness and community participation. Methods: A case study approach was used to collect data from 8 purposefully selected districts - 4 ‘parent’ districts and their respective ‘child’ districts. Across these districts, in-depth interviews were conducted with 44 district leaders and key health sector stakeholders. Thematic analysis was conducted based on initial hypotheses and emergent themes from the collected data. Results: Across all the 8 districts, we identified differences in three key factors motivating community participation. Local politics linked to new job opportunities and promises of a bigger part of the ‘national cake’ (i.e. resources). Respondents indicated tribal reasons, linked to recognition by separating districts along tribal line or even on cultural grounds. Finally, respondents proposed religious interests within districts that had multiple dominant religions. Ideally, the process of splitting was described as participatory. Joint decisions in allocation of assets were taken. Participatory decision-making varied according to interest. Assets were often in bad shape, there were slow elections and recruitment of staff and very little additional funding for service delivery. Conclusions: Three key factors motivate districts to involve their communities as they start operations for the first time. Most of the motivation for community participation is due to political reasons followed by other reasons like size, tribe and religion. The process of community participation is mainly spearheaded by politicians with little involvement of other stakeholders especially the technocrats. Our results are significant for field building because they show how successful achievement of people centred health care reflects underlying political and cultural constraints.
The governance of rights-based health policies: The case of Costa Rica

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ABSTRACT

Costa Rica's health and health system indicators show favorable outcomes ever since universal coverage (UHC) was achieved in the 1990s. With life expectancy at 80 years, child mortality below 10, social health insurance (SHI) coverage at 90% and public health expenditure at 70%, there seems no reason to worry. Nevertheless, Costa Rica's UHC scheme is at risk of being trampled upon by an increasingly empowered private sector. The developments of the past two decades are not (yet) picked up by conventional health and health system indicators. It requires policy and governance analyses that clarify how public actors relate and coordinate their actions to bring a policy to reality. Health systems governance is an often used concept but has rarely been dis-aggregated in analyzable bits. Cunill (2011) applies it to rights-based public policies differentiating these from others. Public actors responsible for the former are obliged to guarantee the enjoyment of the instituted right, which makes these policies demanding. In practice, those actors must make their actions intentional and coordinate these over three dimensions: management instruments, coordination spaces and values. This paper analyzes Costa Rica's health systems governance since the 1994 health sector reform. Primary health care that used to be the responsibility of the Health Ministry, was integrated into the SHI institute, that already provided hospital care. The Health Ministry was left with its underdeveloped function of health system steward. The move initiated a process that further shifted the power on the health care market and resulted in some experiences that represent important lessons learned. Purpose: Progress to UHC is not only determined by the design of a scheme but foremost by its implementation. Understanding such processes requires the analysis of the governance of the health policy arena. Target audience: those interested in health systems and health policy analyses
Governance, health financing structures and health system efficiency: evidence from sub-Saharan Africa

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ABSTRACT

Background Increased health delivery resources is widely considered as an important step in improving the performance of health systems and population health status. While a number of countries have improved resources towards the health sector, this is not always translated into improved health outcomes especially in most developing countries. The lack of resources in these regions requires efficient and effective use of these resources. The purpose of the current study was to estimate efficiency of health systems and identify the role of governance and health financing structures in health system efficiency. Methods The study used data for 45 countries in SSA from 2005 to 2011 sourced from the word bank world development indicators. The parametric ‘true’ random effects stochastic frontier model and Non-parametric DEA model were employed in the analysis of the study. Both cross section and panel data models were employed to enable a more dynamic analysis. Results The results suggest a wide variation in the efficiency of health systems in sub-Saharan Africa. On average health system efficiency was estimated to be approximately 0.55 which implies resource wastage of about 0.45. Improved governance, public sector management and health system financing structure were identified to be positive and significant determinants of health system efficiency. Cape Verde, Eritrea and Madagascar were estimated to be relatively efficient while Equatorial Guinea, Nigeria and Swaziland were among the least performers in terms of health system efficiency. Conclusion The findings suggest a generally poor performance of health systems in terms of efficiency in the use of resources. While resource commitments to the health sector is critical, it is important to also ensure the efficient use of these resources. Improving the performance of institutions within and outside the health sector may go a long way in improving the general health status of the population Key words: Efficiency, Health systems, Health expenditure, Governance, SSA
Women's preferences matter for health systems: a discrete choice experiment on facility childbirth with 3000 women in Tanzania

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ABSTRACT

Background: Reducing maternal mortality requires that women deliver with a doctor, nurse, or midwife; in most countries this is only feasible in a health facility. Yet nearly half of all women in high-mortality countries, such as Tanzania, still deliver at home and those who deliver in facilities frequently bypass primary care facilities nearby to deliver in hospitals. Understanding women's preferences for delivery care is key to building a people-centered health system. Methods: We interviewed all women who gave birth 6 weeks to 12 months preceding the study in 24 clinic catchment areas in Pwani Region, Tanzania. We fielded a structured questionnaire that included demographic and obstetric history questions and a discrete choice experiment. Women were asked to select between two hypothetical clinics for their next delivery, each with different levels of six attributes (cleanliness, privacy, provider medical skills, provider kindness, availability of drugs and equipment, and cost). We estimated preferences for each attribute level using mixed logit models. Results: We interviewed 3019 women (93.0% response rate). 71.0% of women delivered their most recent child in a health facility. 64.9% had completed primary education or higher. 3010 women had complete data for discrete choice analysis. The most highly valued attributes were 'doctor treats me kindly' (B 1.23, p<0.001), 'doctor has good medical skills' (B 0.96, p<0.001), and 'good equipment and drugs' (B 0.71, p<0.001). By contrast, facility cleanliness and privacy were one-quarter as important as kind treatment. Discussion: Women value both technical and interpersonal quality of care in their facility delivery. Process of care measures 'information gleaned from the interaction with the health care worker' were more important than inputs, such as equipment or cleanliness. These results support the importance of investing in competent and caring providers to encourage facility delivery and promote satisfaction with care.
Governance, accountability and participation of different policy actors in evidence-informed policy development: what can we learn from six health policies in India and Nigeria?

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ABSTRACT

Introduction Good governance involves exercise of power to steer society for the public good. Social accountability contributes to governance through regulating different actors’ participation and through creating a transparent and cooperative learning process in a complex environment. Participation of different policy actors recognizes discretion in the use of evidence and collective learning as an important aspect of the policy process in people-centred health systems. However, limited research exists exploring the participation of actors in evidence-informed policymaking in low and middle income countries. Our presentation examines the participation of actors in evidence and policy (EaP) processes in India and Nigeria. Methods We analysed three policies in each country: internationally-prominent; internationally-neglected and health systems policies. The study was guided by a conceptual framework linking EaP processes. Qualitative data was collected using documents review and in-depth interviews and analysed using framework approach. Results Seven groups of actors were identified: i) Government, ii) Academics, iii) Health workers, iv) Development partners, v) Civil society, vi) Private sector, vii) Media. The first three groups were involved in all EaP processes, development partners deliberately excluded from one policy, civil society played a prominent role only in India providing contextual evidence. There was no perceived role of private sector and media in Nigeria. In India, media participated only in the EaP process on HIV/AIDS and the private sector in tobacco policy. Government sub-group analysis revealed that legislators and judiciary appeared to be absent. The absence of actors limits transparency, e.g. influence of tobacco industry on policy. Discussion Evidence perceptions of powerful actors in EaP processes determine the contribution of evidence in policymaking. The actors’ ideological background can shape their contribution, e.g. civil society advocating for vulnerable people. Participation of diverse actors can improve social accountability of evidence-informed policymaking and contribute to democratic governance of people-centred health systems.
Effect assessment of medical reform policy for solving the problem of public hospitals get economic benefit from excessive drug expense in Zhejiang Province

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ABSTRACT
Background: Public hospitals are nonprofit medical and health service agencies built by the government. While, in China, doctors in public hospitals get economic benefit from Excessive Drug Expense. As the prices of medical service is low, doctors tend to prescribe excessive Drug to make a profit, leading to serious problem of irrational-drug use, excessive-medical treatment and strained doctor-patient relationship. The government of Zhejiang province was committed to medical and health reform, a pilot program was carried out in county-level public hospitals in 2011. It is necessary to assess the influence of the policy, and analyze whether the policy aim at fundamental problem. Methods: 1) To analyze the factors cause this problem, we collect and analyze existing data from Statistical Yearbook, describe resource allocation, indicators include Number of Medical Institutions, beds, human resources, service quantity and quality, finance, etc.. 2) To assess the influence of policy, we adopted the method of investigation and qualitative interview to get operation data in 38 pilot hospitals before and after the reform. 3) Use systems-archetype tool to analyze main loop of the system, evaluate whether the policy make right intervention to key problem. Results: The government invested is insufficient. More than 80% of hospitals' income comes from charges, pharmaceuticals income are main sources of hospital financing. In pilot hospitals, according to the policy, drug price was reduced by 15%, as to reduce benefits, prevent irrational-drug use. There was a decline of 6.77% of pharmaceuticals income rate in 2012 compare to that of 2011, but this tendency didn't maintain in 2013, there was a bounce of 0.98%. Discussion: The reform didn't solve the problem of insufficient capital. To some degree, excessive-drug use are less, but doctors still get financial benefits from prescribing drugs.
Access to medicines against CNCDs in Cameroon: lessons learnt from designing an observatory of medicines

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ABSTRACT

Background: Chronic non-communicable diseases (CNCDs) impose the biggest part of their global death toll on developing countries and the related financial burden on healthcare systems doubles that of infectious diseases. In most sub Saharan health systems facing this double burden, while infectious diseases rank as top priorities backed by global health initiatives, patients suffering from CNCDs mostly cope with the mixed health systems especially in settings with very low coverage of health insurance schemes. Hypothesizing that an Observatory of Medicines against CNCDs tailored to disseminate reliable and targeted information to relevant stakeholders would enhance access to medicines, we are implementing a three-year grant from the Alliance for Health Policy and Systems Research. This is the third of three linked abstracts whose objective is to describe and discuss the design process of the observatory and its monitoring and evaluation framework.

Methods: We conducted a multiple methods situational analysis study in the 10 regions of Cameroon. An evidence brief for policy (a synthesis of the situational analysis and a scoping review of global evidence on observatories) was prepared to inform four policy dialogues. The dialogues help to validate the infrastructure, the activities and outputs and the desirable monitoring and evaluation framework.

Results: we will exhibit the lessons learnt from the policy dialogues organized nationwide and present the preliminary results from the monitoring and evaluation framework developed to assess the reach, the users satisfaction and the effects of the observatory on availability, accessibility and usage.

Conclusion: this is an original experience of designing and testing a people-centered intervention using a systemic perspective in a country with a health insurance coverage rate below 2% and where the medicines market mostly operates under private rules. This pilot study should inform future research on pharmaceutical information systems in similar contexts. Promoting patient-centered pharmaceutical information systems potentially equates enhancing equitable access to medicines against CNCDs.
A responsive quality control system improves district health registries in Northern Mozambique

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ABSTRACT

Introduction The quality of health management information systems is often poor in low income countries. The Mozambique HMIS relies on aggregated data, which is collected through weekly and monthly forms by each health centre in the country. An in-depth assessment of the HMIS in the District of Chiure, Cabo Delgado, Mozambique, enabled designing and piloting a responsive quality improvement system at district level. Objective To improve the quality of health registries at district level Method/Approach Monthly quality control of submitted health forms through the district HMIS responsible was reinforced and linked to feedback mechanisms to 9 peripheral health centres of the district during 24 months (2009/2010). The number and types of identified errors in monthly and weekly registries were recorded and discussed with the health centre in-charges on a monthly basis. Data were entered and analysed in EpiInfo. The primary and secondary outcomes were the number of forms with errors over time in monthly and weekly registries and the description of the types of errors identified over time, respectively. Results In all, 41.2% of all forms (1195/2904) contained a total of 1644 errors. 47.9% (1030 errors) and 34.4% (614 errors) of the forms were identified with errors in 2009 and 2010, respectively (Chisq 71.72, p<0.0001). All nine health centres demonstrated a reduction of the number of errors from 2009 to 2010. Identified errors were administrative (47.4%), missing (29.1%), wrong calculation (11.3%) or ‘form not submitted’ (12.2%). While the number of missing values decreased from 345 in 2009 to 131 in 2010, the number of wrong values remained constant at 99 and 101, respectively. Conclusion Quality control mechanisms linked to rapid feedback mechanisms can easily be integrated in district health systems and can effectively improve completeness of the HMIS, allowing founded, evidence-based decision making that respond to people’s need.
The importance of reliable data in improving people-centred health systems: disappointments, delusions and dangers.

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ABSTRACT

Background: Reliable data is essential for planning, managing and financing appropriate people-centred health systems. However, collection and recording of data often places heavy burdens on capacity-limited local providers, even where national Health Information Systems are in place. This report from Northern Nigeria highlights data deficiencies in an otherwise successful health-system-strengthening programme, and is intended to stimulate discussion about prevailing expectations of health-system data from low-resource communities. Methods: Data from the Nigerian Health Management Information System (NHMIS) relating to maternal outcomes in four states of Northern Nigeria were assessed to establish whether NHMIS provided a suitable basis for estimation of maternal mortality ratio (MMR), proportion of deaths in women of reproductive age due to maternal causes (PM) or pregnancy-related mortality rates (PRMR). Availability, completeness, consistency and credibility of datasets were examined and scored for each state over the past 5 years. Annual MMR/PM/PRMR and 95% confidence limits were calculated for each state where possible. Results: Data necessary to estimate MMR or PM rates were not reliably available from the NHMIS. A facility-based PRMR (fPRMR) could be derived but only from 2012 for all four states. Available denominator datasets were inconsistent, even in states with the most complete data sets. fPRMR calculated for all four states was high (1038/105 LB, 95% CI 957–1127/105 LB); fPRMR calculated for all Nigeria was also higher than the WHO estimates, but maternal deaths reported on NHMIS were >75% lower than WHO estimates. Conclusions: The quality of routinely-collected NHMIS data is currently not suitable for monitoring of maternal mortality. There is evidence of increased data entry on NHMIS from all four states during the last five years, but many datasets were incomplete or inconsistent. The challenges of recording reliable data in resource-poor settings are examined and implications discussed. Recommendations for future quality-control and capacity-development are proposed.
Strengthening accountability to patients for cost effectiveness: case of Rogi Kalyan Samithi (Patient Welfare Associations) in Chhattarpur District of Madhya Pradesh in India.

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ABSTRACT

Accountability in Health care is becoming a grave concern in low and middle income countries. In India many studies suggest poor accountability a reason for increasing health expenditure both public and private because of irrational care practices and poor care system. Unaccountability contribute to irrational treatment protocols and prescriptions and loss in quality and value of care. The initiation of patient welfare committees in public hospitals in India called Rogi Kalyan Samiti is considered an innovative way to ensure patient accountability in public health care institutions. However it has been of experience that these institutions in many places do not function or serve the purpose for which it is established. This descriptive research looks in to the functioning of the Rogi Kalyan Samithi in Madhya Pradesh State in India. The District hospitals in Madhya Pradesh are visited to collect data. A total 5 most difficult districts in the state is covered in this study. Most difficult state is defined are states with comparatively increasing health problems. The study describes the relationship between the Performance of the Rogi Kalyan Samiti in the study districts and the care quality in the study districts. It also explores how far the patient empowerment happens in this. The patient empowerment scale shorter version is used.
Strengthening community accountability mechanisms to improve maternal and child health services: The promise of community scorecards

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ABSTRACT
Clinic / community health centre committees (CCs/CHCCs) are platforms for community participation and decision making regarding health. Accountability mechanisms like CCs/CHCCs should be seen as key vehicles from which to address demand barriers for Reproductive Maternal and Child Health services (RMCH). However research has shown that these structures are often dysfunctional and primarily function as forums for complaint and political debate in South Africa and are therefore falling short of their intended use and potential. The Black Sash RMCH project set out to investigate the extent to which a multi-stakeholder approach, whereby we bring together CCs/CHCCs with a range of alternative community accountability mechanisms e.g. CBOs, SGBs etc, would create opportunities for collaboration and problem solving. Qualitative research methods were employed for this study. The findings represented in this paper are based on a baseline study to assess the functionality of existing community accountability mechanisms; ongoing internal monitoring of the training and community scorecard process; a external evaluation; and a series of workshops to get stakeholder input into assessing the intervention. The Black Sash RMCH Project developed innovative training models aimed at equipping communities with practical tools which enable them to monitor service delivery and engage meaningfully with service providers and other relevant stakeholders. As part of our intervention we trained CCs/CHCCs and alternative community accountability mechanisms to jointly implement a Community Score Card (CSC) process in their community. The CSC is a hybrid tool which combines the different accountability approaches of social audit, community monitoring and citizen report card. The intervention was piloted in the two districts of uMgungundlovu in KwaZulu-Natal and OR Tambo in Eastern Cape Province of South Africa. This study summarises the key learning regarding how successful the Black Sash training model was and the potential for up scaling and replicating the approach in other Districts of South Africa.
Development of Bangladesh population policy-2012: Who cooks, who provides recipe?

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ABSTRACT

Background: Since Bangladesh's independence the government of Bangladesh committed to mitigate population problems and formulated a range of policies, including the Bangladesh Population Policy. In developing these policies, NGOs involvement is widely recognized as important in the process. Accordingly effective participation of the people in the formulation of population policy in Bangladesh has become instrumental. Therefore, I did an analysis of the role of the stakeholders in developing the population policies in Bangladesh. Methods: Document review, stakeholder analysis and key informant interviews were applied and triangulated. The 'Policy Analysis Triangle' was used for systematic analysis of the multitude of factors. Result: A range of stakeholders were included in the development of the policy. Yet, people's views were not appropriately translated in the policy. There was no institutional arrangement in place to see whether the people's voices were represented in the final policy. There was less participation from the poor, uneducated, youth, adolescents, women and indigenous people to name only a few groups. People's views were not appropriately translated in the policy. Donors' influence was shrinking or at least it became invisible in the development of the current policy. Conclusion: With low people's participation the policy partly addressed the need of the present population management discourse. Due to the absence of concrete action plan, the policy remains unclear and ambiguous. To avoid political bickering there is a need for intensive research to know people's views before the development of the policy. The constitution of a Parliamentary Standing Committee may be an institutional way to ensure people's participation. There is a need to reduce dependency on the NGOs and to build the capacity of the public sector.
Study on the comprehensive benefits evaluation of major public health service during the health care reform in China, 2009-2011: based on the rural toilets renovation

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ABSTRACT

Background: The rural toilets renovation, as an important part of major public health service, has made significant progress during the health care reform in China. In order to further fasten the implementation of toilets renovation and deepen the health care reform in the future, we are urgent to carry out a comprehensive benefits evaluation of rural toilets renovation, 2009-2011. Methods: The comparative analysis and cost-benefit analysis were used in the comprehensive benefits evaluation, including health benefits, economic benefits and social benefits, among different districts in 2009-2011, based on 1522 households' survey in 459 pilot counties of China. Results: The incidence of fecal-oral-transmission diseases gradually declined year by year. The awareness rates of health knowledge, the formation rate of attitudes toward health knowledge and personal hygiene practices in rural residents continuously increased. The rural toilets renovation has brought both direct and indirect economic double-benefits to peasants households, which becomes the most satisfactory project only second to the New Rural Co-operative Medical System. Meanwhile, the problems presented in construction and subsequent management of rural toilets renovation still need to be put forward and paid more attention to. Discussion/Conclusions: The benefits evaluation of rural toilets renovation in time is very helpful to provide the guidance in the following direction and emphasis of rural toilets renovation in the future. According the results of benefits evaluation, we appeal that the government should continually provide steady and sustained investment and support in the complementation and evaluation of rural toilets renovation, as well as strengthen communication and coordination among different departments in order to facilitate the establishment of follow-up and long-term management mechanisms of rural toilets renovation in China.
The impact of HIV service scale-up on provider accountability and service responsiveness in four Zambian primary health centres: a multi-case study.

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ABSTRACT

BACKGROUND: In countries with generalized HIV epidemics, a large amount of funding continues to be directed towards HIV-specific care and treatment (C&T) with various claims of a 'health system strengthening' effects. This research examined how the introduction of externally funded HIV services influenced performance accountability and thus service responsiveness in Zambian primary health centres. METHODS: An in-depth multi-case study design included four health centres selected for established (>3yr) HIV services and urban, peri-urban and rural characteristics. Case data included provider interviews (60); patient interviews (180); direct observation of facility operations (2 wks/centre) and key informant interviews (14). Using Shiekh et al's Hardware-Software model and Brinkerhoff's accountability framework, data were analysed to explore how new HIV services influenced mechanisms of answerability and enforceability in different health centre domains. RESULTS: In-service training, well-disseminated clinical guidelines, quality assurance support and mentorship contributed to strong individual and team delivery of HIV services during scale-up from 2004-2009. Overtime payments also acted as a positive sanction, improving HIV service providers' morale in the short-term. However, investment in HIV services failed to strengthen weak underlying mechanisms of answerability (collection and collation of cross-clinic performance data) or enforceability (disciplinary mechanisms and leadership). The 2010 cessation of overtime payments, moreover, contributed to declines in HIV service responsiveness. Critically, accountability and service responsiveness were most enduringly influenced by providers' perception of HIV-patients as 'real patients' and 'somehow special', combined with HIV-patients' comparatively strong treatment literacy and capacity to demand quality care. CONCLUSIONS: Investment in health system 'hardware' is a necessary but insufficient condition for improving system-wide accountability in this low-resource setting. Sustained improvements in service quality and responsiveness in primary health centres will be require greater understanding of and investment in changing work norms, leadership and disciplinary mechanisms that shape service and behaviour patterns across the system.
Engaging clients in monitoring healthcare and health insurance services in Africa

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ABSTRACT

Background/ purpose To reduce economic barriers to access healthcare services, health insurance is being introduced in various countries, such as in Ghana, Rwanda and Nigeria. Health insurance generally leads to increased access and utilization of healthcare services. However, the capacity of healthcare providers to offer quality care is often low. Increased utilization and workload easily exacerbate this situation. To improve the quality of services, clients’ can provide valuable input for healthcare- and health insurance managers to build and sustain client-centered services. By engaging clients in monitoring, these service providers can be made aware and understand clients needs, expectations and concerns. This is expected to enhance clients interest to utilize services and encourage provider loyalty and treatment adherence. This paper discusses the development, implementation and findings of a monitoring intervention named 'MyCare' in Ghana, Kenya, Nigeria and Tanzania. Method The cyclical intervention MyCare was designed using the findings of a study in Ghana called 'Towards a client-centered health insurance system', supported with theory and experiences from three other health insurance schemes in Kenya, Tanzania and Nigeria. Results/ significance We describe the intervention's participatory action approach (PAA) and illustrate some results of the 1,850 clients and their healthcare providers (33) and health insurers (4) participating in monitoring quality of services in Ghana, Tanzania, Kenya and Nigeria between 2011-2013. Using different settings to pilot MyCare, participants identified inter-relational aspects of service and transparent information provision as priorities to improve service quality. They then jointly determined actions for improvement. Although impact findings are beyond the scope of this paper, we argue that the intervention -inspired by the P.A.A. and informed by the Socio Ecological Model- contributed to user-emancipation, awareness and multi-disciplinary learning and action. This approach is believed to contribute to client centered quality of healthcare and health insurance services and increased partnership and mutual trust.
Efforts to secure universal access to HIV/AIDS treatment: A comparison of BRICS countries

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ABSTRACT

The BRICS countries represent 43% of the global population. Their political and economic leadership in achieving universal access to ARVs is critically important for the developing world to achieve the above target. Their positive experiences demonstrate that it is feasible to extend the access to ART to the people in need, even in a resource-poor setting, where the ideal health system infrastructure might not be in place. Experiences of them in securing universal access to ARVs could serve as an engine of innovative health solutions for the other developing countries, and contribute in the global effort toward strengthening health systems. This article illustrates how the BRICS countries have been building their focused leadership, making important high level commitment and national policy changes, and improving their health systems, in addressing the HIV/AIDS epidemics in respective settings. Specific aspects are focused on efforts of creating public provisions to secure universal access to ARVs from the aspects of active responsive system and national program, health system strengthening, fostering local production of ARVs, supply chain management, and information system strengthening. The most important contributors to the success of response to HIV/AIDS include: creating legal basis for healthcare as a fundamental human right; political commitment to necessary funding for universal access and concrete actions to secure equal quality care; comprehensive system to secure demands that all people in need are capable of accessing prevention, treatment and care; active community involvement; decentralization of the management system considering the local settings; integration of treatment and prevention; taking horizontal approach to strengthen health systems; fully use of the TRIPS flexibility; and regular monitoring and evaluation to serve evidence based decision making. This study touches cross-cutting research topics of governance, accountability and participation; health equity and rights; and complexity science and people-centered systems.
Where there's 'willingness' there's a way: strategies to harness the private health sector for maternal and child health related information sharing

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ABSTRACT

Background: The private for-profit health sector in India is a significant service provider in maternal, newborn and child health (MNCH) and clients generally view private providers as more responsive and client centred than public ones. However, the private sector shares very limited health data with the public sector, partly due to mutual mistrust and lack of a legal framework. In this study we explored whether and how the public and private health sectors in the north Indian state of Uttar Pradesh might engage in increased sharing of MNCH health data and collaborative decision making. Method: 27 in-depth, semi-structured interviews were conducted with national, state and district level stakeholders in 2013 to elicit their experiences, views and recommendations on developing a strategy for data sharing between the private and public sectors. Results: Private sector stakeholders were willing to share data if it was connected to public health goals. We identified six major pillars of a potential data sharing strategy: 1. Engaging with organised groups and associations rather than with individual providers; 2. Rapport building among key private and public sector stakeholders; 3. Sensitisation of key stakeholders to the concept of data sharing, and its significance for participatory public health decision-making; 4. Inclusion of selected private sector actors (e.g. the more socially oriented ones) to begin with; 5. Developing user-friendly common data formats and collection and analysis processes; 6. Provision of a mix of incentives to private players for their participation (e.g. contribution to publications, travel allowance for meetings). Discussion/conclusions: There is a latent willingness in the private sector to participate in public health information sharing and local decision making, which can be harnessed through appropriate strategies. This study has the potential for transforming local health information systems in similar settings, which currently comprise only public sector MNCH data.
Feasibility of health information visualization for evidence based decision making in urban Bangladesh

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ABSTRACT

Background: Urban health systems in Bangladesh are in disarray with limited or no technical and/or managerial capacity to regulate, plan or provide basic services to a rapidly growing urban population. The result is a dysfunctional and inequitable urban health system characterized by poor quality, duplication of services and primary care coverage gaps especially for the poor. Improved decision-making based on evidence is needed to strengthen weak governance and service delivery in urban health systems. This paper assesses the feasibility of an information visualization platform designed to assist in health systems decision making and planning in urban Bangladesh. Methods: Using data from a health facility mapping exercise in Sylhet City Corporation, this study attempts to create an interactive and practical web-based platform for decision makers. The platform incorporates data on all service delivery points including geo-spatial coordinates, service types and operation hours, available health human resources and provision for the poor. The acceptability and utility of the tool are currently being assessed through stakeholder consultations with policy makers and planners at municipal and national levels. Results: Perceived benefits of the interactive platform include evidence-based resource allocation, improved accountability, increased equitable coverage, and rationalized referral networks. User perspectives from the assessment will help refine the interactive interface, and improve its effectiveness in strengthening health information systems and supporting urban policy and implementation. Conclusion: Information visualization tools have proved useful for a variety of purposes in developed country settings. This open source interactive platform holds promise in translating this success to the field of urban health systems planning in highly pluralistic and unregulated health markets.
Corruption in the health sector: an analysis of health leaders' and managers' perceptions on corruption by age

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ABSTRACT

Background: Corruption erodes health services quality and access, particularly in low- and middle-income countries. A people-centered health systems approach requires developing advocates and practitioners of democratic decision making and social accountability. Healthcare workers' experiences with corruption can inform recommendations for combatting corruption in the sector. Methods: A survey hosted on statpac.com in July 2013 queried health managers and leaders on factors contributing to health sector corruption, and the effectiveness of interventions on reducing corruption. Likert scale question responses were disaggregated by age, and age categories were analyzed for statistically significant inter-group differences in Epi Infoâ“¢ version 7.1.0.6. Results: 1,076 respondents from 95 countries completed the survey. Among the statistically significant findings (p<=0.05), fewer younger respondents (<30) ranked factors 'highly important' in contributing to corruption compared with older respondents (>60), including limited enforcement of laws (70.4% vs 83.3%), lack of effective corruption reporting system (68.5% vs 85.3%), cultural values/societal acceptance of corruption as normal (41.5% vs 70.2%), lack of health workers' ethical/moral integrity (50.9% vs 70.2%), and nepotism (61.1% vs 77.3%). Younger respondents had greater belief in the effectiveness of international organizations in reducing corruption. Discussion/Conclusions: Older respondents have a less encouraging but perhaps more realistic view, possibly due to longer exposure to health sector corruption. Of particular interest is the difference between younger and older respondents' views on the importance of societal acceptance of corruption as normal, and lack of ethical/moral integrity among health workers. Corruption is learned, and practiced in the context of socio-economic realities. By engaging youth in leadership development activities aimed at cultivating agents of positive change, corruption's status as a norm can change as youth rise in the ranks of health sector leadership, management, and governance positions. Capitalizing on youth's belief in the effectiveness of international organizations in reducing corruption is one place to focus programmatic youth engagement efforts.
Examining priority setting and resource allocation practices in hospitals: The case of county hospitals in Kenya

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ABSTRACT

Background Hospitals play a critical role in health systems and consume a large proportion of resources. However, few studies have examined priority-setting in hospitals, particularly in developing countries.

Methods We conducted a case study of priority-setting practices in two County hospitals in Kenya. We conducted 70 interviews with hospital decision makers, reviewed key documents and conducted 7 months of non-participant observations. Data were analyzed using the thematic approach. We described priority-setting practice using a policy analysis framework that examines the context, process, content and actors.

Results

The process and content of hospital priority-setting practices were found to interact with a number of contextual factors namely 1) resource scarcity 2) financing arrangements 3) decision space, 4) leadership and management and 5) organizational culture and micro-practices of power among the actors in the priority-setting process in a number of ways. For example, severe resource scarcity, over-reliance on user fees and domination of the values of non-clinician managers turned hospitals into 'revenue maximizers' with perverse outcomes such as the unfair allocation of budgets that favor high revenue generating departments. Because of reduced decision space for the hospital planning process, scarce resources and bureaucratic delays by the central government, the annual hospital planning process was not considered important by the hospital managers, was not aligned to the hospital budgeting process and was not implemented. The exclusion of middle level managers from decision making processes in one of the case hospitals resulted in perceptions of lack of transparency and unfairness in budgeting decisions, while the inclusion of all managers in decision making processes in the second case hospital led to perceptions of fairness and transparency.

Conclusion

Understanding or improving the process and content of priority-setting practices in hospitals requires an examination of, among others, the identified contextual factors and the power relations between actors.
Improving quality and use of routine HMIS data in Sofala, Mozambique

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ABSTRACT

Background: Informed decision-making is essential for effective management and resource allocation, and to achieve high quality, responsive health services that meet population health needs. Effective, contextually-appropriate models are needed to engage health system managers at the provincial, district and facility levels in the process of improving the quality of routine data and strengthening their use for decision-making.

Methods: The Mozambique Population Health Implementation and Training Partnership aims to improve health outcomes in all 13 districts of Sofala province by strengthening health systems and improving the delivery of primary health care. Annual data quality assurance assessments are carried out at 26 of the 146 health facilities in Sofala Province to assess HMIS availability and concordance for primary health care data. Aggregate availability and concordance measures are calculated for each facility, including all sources from facility-based paper instruments to district and province-level computerized HMIS. Concordance is categorized using Global Fund ratings, with a margin of error below 10% considered highly concordant. In an effort to encourage data use for decision-making, district-level meetings bring together front-line health workers and district managers for performance indicator review, performance gaps identification, solution planning, and action plan monitoring. Results: Between 2009-2012, average data availability increased from 84.6% to 97.6%. Concordance improved from 54.1% to 83.4% highly concordant data. Concordance was lowest between registry books and facility reports, increasing from 34.5% to 64.5%. By 2012, 21 (81%) facilities achieved data concordance over 80%, and 6 (23%) above 90%, compared with 1 (4%) with over 80% (0 over 90%) data concordance in 2009. Discussion: Active involvement in data use by health staff from all levels democratizes information in an effort to identify and prioritize problems. Simple, low-cost models are available to improve routine data quality, and foment informed decision-making to develop highly effective health systems responsive to patient needs.
Can parliamentary action advance the right to health?
experiences from East and Southern Africa

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ABSTRACT

Background. Parliaments can play a key role in building responsive health systems through promoting the right to health. Aim. To describe experiences of parliamentarians from South and East Africa concerning parliamentary oversight, adopting legislation and understanding of human rights

Methods. A semi-structured questionnaire administered to 20 respondents from ten countries attending a meeting of the Southern and Eastern African Parliamentary Alliance of Committees on Health in September 2008. Results. Parliamentary committees’ legislative and oversight work is rarely framed in terms of the right to health. Knowledge of the application of international human rights laws to health was limited. Parliamentarians were more likely to be familiar with intellectual property rights and non-binding commitments such as the Abuja Declaration than with the substantive content of the right to health, despite most countries in the region having ratified key international human rights laws. Nonetheless, parliamentary debates on health budgets and programmes were frequently based on human rights claims aiming to influence resource allocation in favour of vulnerable groups, with strong participation from civil society. Although parliamentarians were aware of the resource limitations constraints, they were not familiar with the concept of progressive realisation as a mechanism to make rationing more transparent and defensible within a rights framework. Conclusions Human Rights conventions impose regulatory and programmatic obligations on governments, which require parliamentary oversight. Important gains could result if work around progressive realisation was able to integrate budget decisions and oversight of executive resource allocation within a rights framework. Increasing inclusion of the right to health in National Constitutions in the region since 2008 provides important opportunities to engage parliamentarians. The findings highlight the importance of building capacity amongst parliamentarians to use rights-based analyses in their parliamentary roles to advance the right to health in the region as part of building people-centred health systems.
Towards evidence-based health reporting for people-centered health systems

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ABSTRACT

Background: Media plays a vital role in shaping public health policies and opinions. This study aims at exploring the role of media in informing health policies, identifying factors influencing health reporting and investigating the role of evidence in health journalism including the quality of health reporting. Study identifies strategies to strengthen the role of media for people centered health systems. Methods: Media analysis was conducted to assess the way media reported on public health related issues including the type and quality of evidence used. A quality assessment tool was developed and piloted. Semi-structured interviews have also been conducted with 45 journalists, researchers, policymakers and stakeholders using validated interview questions. Results: Out of 1,279 health-related news articles, 328 articles used certain type of evidence to report on public health. The majority of these articles relied on experts opinions as their source of evidence and only 1.9% reviewed referenced peer-reviewed research studies. The quality of health reporting was found to be low overall. Interview findings showed that media is not fulfilling its investigative role due to poor capacities to access and use evidence and the lack of proper follow-up. While policymakers and researchers viewed media as an important tool for evidence-informed health policies, serious concerns were voiced in terms of the current practice and capacities. Journalists highlighted critical issues that impede them from referring to evidence in reporting. Conclusion: People-centered health systems require effective evidence-based health reporting. Our study provides a structured reflection on the role of media and the factors that influence health reporting including context-specific strategies that would enhance the quality and promote the use of evidence in health reporting. Findings from this study can contribute to the efforts of redefining the role of media in strengthening health systems in countries.
Governance in the South African health sector: An in-depth analysis of financial management processes at a district level

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ABSTRACT

Background: The World Health Organisation (WHO) considers governance to be a key component of the health system. Nested within a broader project funded by the Resilient and Responsive Health (RESYST) consortium in South Africa (SA), this doctoral study is focused on micro-practices such as daily activities, routines, decision-making authority and interaction of actors and their contributions to financial management processes at district level. Methods: The RESYST project will make use of an action learning approach. The study will be conducted in one district in the Gauteng province of SA. Purposive sampling will be used to identify key managers (n=30) involved in financial management processes. Document reviews and semi-structured in-depth interviews (conducted between March-June 2014) will provide insight into district financial management processes. Thematic content analysis will be used to distill the study findings. Expected findings: The presentation will provide an overview of district and sub-district plans over time, how decision-making and review processes work, the interface between strategic planning and routine practices such as procurement, as well as the role of provincial-district relationships and engagement. Drawing on the experience of other RESYST learning sites in Kenya and Western Cape, the link between plans, targets and operational budgets are likely to be weak despite review processes. Significance: This study will draw out the implications for financial management, and efforts to strengthen governance processes at the district level in SA, and other low and middle income settings.
Training and support of district clinical specialist teams in seven provinces in South Africa

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ABSTRACT

District Clinical Specialist Teams (DCST) are one of the streams which underpin the re-engineering of primary health care in South Africa. Established in 2012, their main role is to reduce maternal and child mortality and morbidity. A five module Induction and Orientation training programme was developed based on the recommended framework set by the Ministerial Task Team (MTT). Focus The intention of the training was to orientate the newly formed teams into their roles and to equip them with the necessary tools to improve maternal and health outcomes. The content over 5 modules included: Orientation, situation analysis, prioritisation, planning and reporting, leadership, clinical governance and the integration into the other streams of PHC and programmes. The extensive collaborative processes included: - Rapid content development within the terms of reference as set out by the MTT - Panel of experts (via an email list) reviews contents and provides input - Training of the trainers with content revision to be in line with feedback from the panel and trainers - Training is done by a team of content developers, senior consultants and DCST facilitators - Pilot training is done before roll-out and content adjustment is made as necessary - Pe-workshop meetings are held with the provincial coordinators and team leaders - Formal feedback reports are written for each workshop and contain feedback from participants, details on the workshop and facilitation processes - Records of each workshop are kept such as: photographs, attendance registers, feedback forms, presentations made by participants and facilitator, resources and handouts. Significance The methodology and processes involved in the induction and orientation training can be applied to other national training endeavours and is a good example of a rapid but effective national roll out of a modular training package. The Orientation and Induction training provided a platform to anchor the DCST and to orientate them to instil a culture of clinical responsibility and accountability that improves systems, quality and safety.
Realising the right to health: implementing values of participation in people centred health systems

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ABSTRACT

Background This paper focuses on participation and accountability aspects of people-centred health systems. These are important for implementing the right to health and promoting equity. Internationally, in recent health systems reforms, there is an ongoing challenge to ensure participation is genuine and that it has influence. In this paper we explore contexts of formal and informal participation and the challenges encountered. We do not valorise formal or informal participation but argue both modes are required for accountability. Methods The paper reviews recent cases from England and analyses primary research from South Africa collected using a mix of methods. Data is analysed using a conceptual framework of accountability and participation as both mechanisms and values. Results In the UK recent enquiries into health care failures have found participatory mechanisms to be in place but evidence of poor care gathered through these systems have not been valued alongside other data sources or has been ignored. Complaints procedures have not been sufficiently robust to hold rights duty bearers to account. It has only been through informal participation that weaknesses have come to light. In South Africa, much weight is being placed on participation through health committees however the purpose, functions and resources for such committees varies across contexts. In some situations the health committees are top-down structures with limited genuine representation. The variability poses challenges not only to which issues are raised, but also to how these structures can function as accountability mechanisms. As in the UK, informal mechanisms have also been found to be a vital part of the participation landscape. Conclusions While mechanisms for participation are in place, implementation may be weak and the values underlying mechanisms have been missing. To enable genuine participation and people centred health systems both mechanisms and values of participation need to be developed.
How can action research improve district workforce performance and contribute to a more people-centred health system? A look at a research protocol

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ABSTRACT

Background: Most countries in Sub-Saharan Africa (SSA) lack an adequate, well-performing health workforce to move towards a people-centred health system and achieve universal health coverage. Improving the performance of existing and future health workforce will complement scale up initiatives and also strengthen general management capacity. The PERFORM project uses action research (AR) to enhance understanding of how and under what conditions strengthening of district health management can improve health workforce performance. Improving management capacity of district health management teams (DHMTs) is a positive step towards attainment of a more people-centred health system. This presentation will focus on two challenges in our methodology. Methods and Analysis: The study is taking place in three districts each in Ghana, Tanzania and Uganda. In action research (AR) studies, the people who are closest to the problem, (here DHMTs), lead on planning, implementation, observation, reflection and the revision of the strategies. DHMTs are being supported by teams of researchers from each country and Europe. 'Bundles' of human resource (HR) and health systems (HS) strategies will be developed and implemented by the DHMTs to strengthen priority areas of health workforce performance. Analysis of the process and impact of the AR approach on management strengthening will be undertaken in each district. A comparative intra- and inter-country analysis will add new knowledge on the effects of the HR/HS bundles on DHMT management, workforce performance, the wider health system and its context. Discussion: Deciding how to record AR processes and how to compare and evaluate different AR approaches in complex health systems was challenging. The authors searched the literature for options on how to record AR processes. Diaries were selected for their simplicity and clarity. A mixed methods approach is being developed to compare the AR processes, outputs and outcomes in the nine districts. The scope of our comparative AR approach will be explained.
Primary health care managers' public health and general management competencies within the primary health care re-engineering framework in South Africa:
A qualitative assessment

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ABSTRACT

BACKGROUND The Primary Health Care (PHC) Re-engineering strategy in South Africa requires competent and accountable managers to drive the implementation of PHC towards achievement of health outcomes. Therefore an assessment of the competencies and engagement of facility managers in the planning and capacity building are needed in order to develop targeted strategies to strengthen management capacity towards their delegated responsibilities. OBJECTIVE To assess the general management and public health competencies of PHC facility managers and PHC outreach team leaders (ORT) in order to identify competency gaps. METHODOLOGY Focus group discussions (FGDs) were conducted with purposively selected PHC facility managers, supervisors and ORT leaders in selected sub-districts in five provinces between December 2012 and April 2013. Twenty three FGDs were analysed using content analysis to develop common themes. FINDINGS Findings were consistent across the provinces with participants revealing lack of involvement of facility managers in the planning process, as a key to poor understanding of the vision and mission of the Department of Health compared to the ORT leaders, and how to translate this knowledge to drive operations at facility level. The lack of training was key to the following identified public health competency gaps; lack of skills to conduct community assessments, and weak data analysis and interpretation abilities. The competency gaps were compounded by system challenges such as staff shortages, poor infrastructure and poor responsiveness of higher-level managers. CONCLUSION The identified common competency gaps among facility managers need to be addressed, along with the need to strengthen support services at district and provincial levels. The study revealed a need for facility managers' involvement in the PHC re-engineering planning and capacity building initiatives. The study revealed the need for training in the planning and management of labour relations matters, human resources, medical and other operational supplies, patient records and time management.
Implementation research to strengthen community engagement through village health committees: A case study in multi-stakeholder collaboration

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ABSTRACT

BACKGROUND: Implementation research seeks to understand the disconnect between what is supposed to happen and what actually happens. Programs and policies to improve health systems often fail to deliver as expected once implemented in the real world due to a lack of enabling institutions and unanticipated contextual features. India's village health committees (VHCs), envisioned as crucial mechanisms for enhancing community engagement in health, are no exception. The Strengthening Village Health Committees for Intensified Community Engagement at Scale (VOICES) study is conducting implementation research to inform a support package for VHCs. VOICES provides a rich case study of the complexities of conducting implementation health systems research, particularly around bringing together a multi-stakeholder team with a range of power positions, experiences and interests.

METHODS: We conducted observation of interactions, interviews with stakeholders, and document review of project materials. Thematic network analysis was used to identify themes, develop connections between these themes and explore sub-themes.

RESULTS: VOICES involves twelve institutional stakeholders, including Western universities and funders, national Indian research centres, state governments and small non-governmental organizations. These institutions interact through a variety of channels, entailing different relational dynamics. They provide and seek guidance, training and resources from one another and hold varying types of power, which fluctuate in salience depending on the issues at stake. The extent to which different stakeholders collaborate to enable nuanced implementation research depends on the political context, alignment of interests, strength of relationships and project's capacity to nurture adaptive spaces.

CONCLUSIONS: The complex partnerships required in implementation research echo the complexities of implementing health interventions. Rigid protocols, inflexible agendas and glossing over tensions can damage relationships and limit positive outcomes. However, when an enabling interactive space is generated and when attention is dedicated to building partnerships and addressing tensions, implementation research can draw strength from this complexity to achieve common goals.
Patients' choice of providers as a signal of quality of care. Evidence of twelve public hospitals in the province of Buenos Aires, Argentina

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ABSTRACT

Health care networks in developing countries are poorly organized. Formal norms and protocols are scarce and informal referrals based on contacts among professionals across services are frequently identified. In addition, the actual operation of health care networks show patients attending directly to hospitals' emergency rooms instead of looking for care mainly at primary health care facilities. This conduct creates underutilization of health posts and over-demand of services at crowded hospitals, even when low-risk related care is required. This research aims to show that the current situation is the expected output from people- rational behavior, who 'shape' the structure of health networks based on perceived quality gaps across facilities, and reorganizing health care networks as a reaction to strategic gaps in public policy interventions. The team identifies eight priority groups of procedures, and develops multiple choice guides to collect perceptions about facilities and people’s reactions from 296 users and 308 physicians and other health workers in twelve public hospitals located on the seven western Great Buenos Aires departments, in Argentina. The information was complemented with in-depth interviews with Municipal Secretaries of Health, and Hospital Directors. Data collected allowed to design a set of bivariate tables and figures as well as estimating a set of logistic regressions based on users' behavior, and staff's perceptions about people's motivations. Results support people ability to identify services' quality. They direct their consultations based on staff- expertise, availability of inputs and clinical studies, as well as infrastructure. The document concludes that a solid health care network requires listening people's decisions, translated in the way of choosing their sources of care. They provide relevant insights about what procedures, technologies and patterns of care should be prioritize in order to build a sound structure of attention, based on users' decisions.
A cross-country analysis of health systems assessments: findings on health governance

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ABSTRACT

Governance is an increasingly recognized component of health sector analysis. Country health officials, donors, and policymakers need solid data to inform health sector reform across multiple areas; including policy frameworks, performance management, and decentralization. The authors sought to determine if cross-country analysis could complement country-level data by illuminating governance patterns, flagging common entry points, and categorizing shared factors to inform performance improvement solutions. A cross-country analysis of 22 Health System Assessments (HSAs) conducted between 2006 and 2012 considered 17 indicators within six categories of concerns (citizen voice, government responsiveness, client power, service delivery, compact, and information reporting) at two levels: how often HSAs mention each indicator and whether the indicator was rated negatively or positively by the assessment team. Coders based these positive or negative ratings on the extent to which the assessment reflected the normative statements of the indicator, the importance of the finding within the text, and the extent to which recommendations derived from associated indicators. Findings from the analysis showed that cross-country analysis highlighted governance challenges that pervade health systems. Commonly, poor information availability and transparency led to minimal data use for advocacy, resource allocation, or planning. Countries lacking health sector information were unable to effectively regulate service provision through legislative frameworks; relying on colonial era legislation that rarely reflected current realities. In countries where updated legal frameworks had been proposed, weak legal drafting skills and citizen engagement led to a narrow pipeline for creating draft legislation and insular government decision making. Cross-country analysis showed that stakeholders should carefully consider broader governance structures that support health systems, such as information technology, civil service, and political reforms. Developing information systems and improving citizen engagement strategies would have a profound impact on planning and implementation. Likewise, legal drafting capacity would facilitate the development of country-specific legislative frameworks.
Translating data into knowledge for decision making by communities, health professionals, and district health management teams

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ABSTRACT

Background Governance, participation and accountability are limited in part by a lack of high quality timely data, and limited data literacy amongst local decision makers. In combination, both factors present an important challenge to improving survival for all in low income settings. Both demand and supply side data is needed if users and suppliers of health services are to reach consensus on the best course of action in their setting, and maximise the potential of available life saving resources. Methods In the context of a quality improvement project in southern Tanzania and eastern Uganda, 'EQUIP', different district-level data sources have been synthesised and tested as a means of informing decision making for improved maternal and newborn health outcomes by communities, health professionals, and district health managers. Specifically, population based household surveys were implemented and used to report on use of health services and coverage of interventions, facility surveys were implemented and used to report on readiness to provide good quality services, and health management information system data was extracted to report on facility workloads. Results Communities, health professionals, and district managers were all receptive to district-level synthesised data on maternal and newborn health care. Examples of different data synthesis formats for the three groups of actors will be presented. Further, insights will be shared about the utility of different data sources for decision making by these actors, including periodicity and timeliness of demand and supply side information, and the facilitation required to support interpretation of different data sources. Discussion Governance, participation and accountability can be fostered by making local data available, and by supporting capacity for local data literacy. Both making data accessible and supporting data literacy were required inputs to maximise the potential of local actors to build consensus about the decisions they needed to make.
Regular doctors, alternative providers, and quacks': Allopathic dominance in the medically plural public health system of India

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ABSTRACT

Background: In addition to the allopathic (Western) system of medicine, the government of India endorses Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homoeopathy (collectively known as AYUSH), extending accreditation, regulation, provision and administrative support to these systems of medicine. The National Rural Health Mission, launched in 2005, sought to bring AYUSH into mainstream health services to improve patients' access, and optimize the roles of healthcare providers. Strategies included the appointment of practitioners of AYUSH in government health facilities, in most cases working alongside, and supervised by, allopathic practitioners. Methods: We studied factors that facilitated or impeded the integration of AYUSH practice into mainstream health services in three states of India. Besides review of policy documents, we conducted 196 in-depth interviews with health system administrators, allopathic and AYUSH practitioners, and community representatives, to access their experiences of integration. Results: A key finding was allopathic dominance in the governance of the public health system. The power differential, among practitioners and advocates of allopathic medicine on one hand and those of traditional, complementary and alternative medical (TCAM) systems on the other, both stems from and feeds the hierarchy of medical systems in India, with allopathic medicine at the top, the AYUSH systems next (in varied hierarchies themselves in different regions), and practically no role or recognition of other TCAM systems, including local traditions. This hierarchy, expressed in the way evidence is defined in different medical systems, in policymaking, in funding allocations, and in the administrative structure and day-to-day running of plural health facilities, is detrimental to the current and future of TCAM in India. Conclusion: An effective plural medical system will require affirmative actions propagated by the allopathically dominant leadership as well as the TCAM participants, and could include equity in budgetary allocations and administrative structures, awareness-raising campaigns about TCAM, and orientation in medical education.
Exploring governance at the level of implementation: Managing relationships

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ABSTRACT

Background Governance is often understood as the structures and processes for ensuring authority and accountability in a system. Working at the level of implementation, we explore another complementary angle by specifically looking at governance within and of relationships. South Africa has a system of cooperative governance. In Cape Town, a large metropolitan district, both provincial and local government are responsible for providing services and technical support in the same geographical sub-districts. A new provincial post, created to support the HIV/AIDS, STI and TB (HAST) programme within a sub-district, created role confusion between programme staff supporting facility services. In this case study we ask: how can implementation problems between two authorities be addressed, and what does this teach us about local level governance?

Objectives Explore the causes and effects of role confusion in the sub-district HAST programme, the intervention implemented to resolve it and the lessons learnt in the process. Methods An action learning approach involving a task team of programme managers was used to design and implement an intervention addressing the role confusion. A theoretical governance framework (Hill and Hupe, 2009) was used in the post-intervention reflection to make sense of the lessons that emerged. Results In the system of cooperative governance, HAST programme staff and their managers found they needed clear a understanding of respective and differing job descriptions, communication lines and policy implementation pathways across the two authorities. Rather than devise strict roles and responsibilities, they opted to negotiate and operationalize a set of shared relational norms and values to manage organisational and interpersonal relationships. The participatory action learning approach enabled the sub-district programme managers address structural governance constraints in a flexible and innovative way, focusing on governance of relationships. This is an important contribution to understanding what is required in governance at the level of implementation.
Training and deployment of human resources for health in rural Africa: A systematic review and policy synthesis

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ABSTRACT

Background: Africa is enduring a human resources for health (HRH) crisis. Most countries in the region lack adequate personnel to deliver basic health care, especially in rural areas, impeding the achievement of the Millennium Development Goals. Effective planning and management of scarce HRH, particularly pertaining to MDGs 4 and 5, are of critical importance to Africa. Methods: To inform such planning, a rapid systematic review of evidence on training and deployment policies for doctors, nurses and midwives for maternal-child health in rural Africa was undertaken. A scoping review of 14 peer-reviewed literature databases was completed, and non-peer reviewed and policy documents were obtained through systematic searches of selected government and international organizational websites. Additional documents not available online were provided by an international Advisory Group. An in-depth policy synthesis was then conducted for a selected subset of countries including Ethiopia, Ghana, Mali, Mozambique, Niger, Tanzania, Uganda and Zambia. Results: There was a paucity of evidence on these policies, particularly on their development, implementation, or impacts. In discussion with the Advisory Group, several cross-cutting political, economic and social issues affecting the policy process in these countries emerged. These included a substantial policy-implementation gap, underfunding of the health sector, a lack of policy visibility, unavailable evidence, a spirit of innovation, the importance of political stability, the challenges of matching services with competencies and aligning donor funds with national priorities, and a lack of capacity for monitoring and evaluation. Conclusion: Addressing these issues, and building upon identified strengths, is paramount to Africa's efforts to strengthen health systems through increased presence of HRH in rural areas to equitably improve the health of their populations, particularly their most vulnerable mothers and children. The purpose of this session will be to present and discuss these issues with a view to identifying potential means of addressing them.
An evaluation of gender mainstreaming by the ministry of public health in Afghanistan to make health policies and services people-centred

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ABSTRACT

Background: Afghanistan emphasizes the importance of gender equity and improving the health status of its people. The Afghanistan National Development Strategy (ANDS) and the National Action Plan for Women in Afghanistan (NAPWA) mandate all ministries have a gender department, improve gender equity internally and integrate gender into its functioning. This outcome evaluation highlights the Ministry of Public Health's (MOPH) success and challenges in mainstreaming gender. Methods: This case study methodology involves reviewing policy documents and plans, and conducting key informant interviews with the Ministry of Women's Affairs (MOWA) to understand their role in monitoring NAPWA's implementation, highlight challenges in gender mainstreaming and understand coordination efforts across other ministries' gender units. The third pillar of NAPWA on Economic and Social Development is supported by three ministries: Ministry of Rural Rehabilitation and Development (MRRD), MOPH and Ministry of Higher Education (MOHE). Gender departments of these ministries were interviewed to learn about their establishment, and development and implementation of their national gender strategies (NGSs). Donors and implementing partners assisting in gender mainstreaming efforts were also interviewed. Data collection is being conducted from February-July 2014. Results: Initial analyses show all three ministries have established a gender department. MRRD and MOPH are implementing their approved NGSs, while MOHE is finalizing its NGS. The MOPH, with assistance from donors, has conducted several activities to implement its NGS, such as reviewing human resource policies to ensure gender sensitivity in hiring and salary negotiations, advocating for greater use of gender-sensitive health indicators, training providers to diagnose and manage gender-based violence (GBV) clients, etc. Discussion: Despite the political, social and economic instability of Afghanistan, there has been significant progress in recognizing the need to address gender disparities in health. With collaboration and capacity-building, greater strides can be made in mainstreaming gender to make health policies and services more people-centred.
Training county governments in Kenya to adopt strategic planning processes

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ABSTRACT

The creation of 47 county governments in Kenya and subsequent devolution of certain health services offer opportunities to introduce more efficient health planning mechanisms. New opportunities, however, breed new challenges. The Public Financial Management Act required counties to develop County Integrated Development Plans within the first six months of the new arrangement. To develop these plans, county governments quickly needed to acquire the skills to plan for new infrastructure, staff arrangements, and service scale-up. In September 2013, the USAID- and PEPFAR-funded Health Policy Project provided technical assistance to the Ministry of Health (MOH), Kenya to train county government staff in developing health strategic plans. The MOH trained 230 staff members from the 47 counties using the MOH County Strategic and Investment Plan Guidelines. The training covered strategic planning methods, national health priorities, appropriate data sources, and stakeholder involvement. Forty-seven county health strategic plans were developed and included in the County Integrated Development Plans. County governments also consulted with civil society organizations, secured county assembly validation, and received cabinet endorsement of the plans. The completed strategic plans enabled the county departments of health to convince the county assemblies to adopt a more rational methodology for investing in health, and to advocate for increased autonomy from the national government. Strategic plans are crucial for county governments to promote and defend health investments. In Kenya, training county governments in strategic planning has led to more rational investment decisions and greater clarity for decision-makers at all levels. While challenges remain, Kenya's counties are developing the systems needed to guarantee the right to the highest attainable standard of health for all Kenyans.
Organizational infrastructure for service delivery: A case study of post-conflict Northern Uganda

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ABSTRACT

In post-conflict settings, service coverage indices are unlikely to be sustained if health systems are built on weak and unstable inter-organization architecture. The objective of this study is to assess the organization level architecture that supports the provision of priority health services in the post conflict northern Uganda as a means to benchmarking system development into the future. Data collection sought to establish the relational networks among agencies supporting the provision of 1) HIV treatment, 2) maternal services and 3) workforce strengthening. The findings are based on 87 agencies that were identified from 48 agency interviews in the three post-conflict districts in northern Uganda. Name generator questions were used in the interview to yield a list of agencies that were supporting the respondent organizations to provide each service in the previous financial year. The findings show that inter-agency collaborations are mostly focused on HIV and least for workforce strengthening. The networks for HIV treatment and maternal services were about 3 to 4 times denser relative to the network for workforce strengthening. The findings show that the network for HIV treatment explains between 69 to 81 percent of the aggregated network in the districts of Gulu and Kitgum. In contrast, the network for workforce strengthening contributed the least (6% and 10%) in these two districts. Although inter-organization networks supporting a remote and young district (Amuru) were under invested with few collaborating agencies and sparse connections, they were more integrated. Gulu District had comparatively more funding agencies among its network core agencies. Basic information about the Inter-agency collaborations - their structure, size and functions can contribute information for building equitable organizational networks as well as leveraging them in terms of communication, resource flow and boosting the delivery of health services.
Health information systems in sub-Saharan Africa: A deductive, mixed-methods theoretical and empirical research agenda toward a systematic assessment of sustainability

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ABSTRACT
Purpose: As domestic investments in HIV/AIDS programs rise and donor funds stagnate, it is increasingly important to leverage country ownership and build sustainability. There is active dialog in the literature about sustainability, but little empirical evidence on its drivers, nor on interrelationships between these various proposed theoretical constructs. Health information systems (HIS) have emerged as a development investment to foster health system strengthening and long-term improvement in outcomes. HIS have significant potential to increase quality of care and to improve work-load and -flow for health workers, but many have been built with and are dependent upon donor funding. Here we present a deductive, mixed methods multi-stage research project to explore sustainability of health information systems among PEPFAR-funded partners in sub-Saharan Africa. Focus: The aim of this study is to contribute evidence on the drivers of sustainability for large global health initiatives. The study builds upon a predominately theoretical literature, and constructs a research agenda to test and refine dominant correlates of sustainability. Significance and target audience: Based on a review of the existing literature, we have developed a new conceptual framework of the determinants of sustainability; and have tested the construct and content validity of this framework via qualitative research with stakeholders from three PEPFAR-funded HIS projects in southern Africa. We translate these findings into a research proposal for quantitative assessment of sustainability, both to further validate the framework and to measure these constructs at baseline among a larger group of HIS stakeholders. Such research can help policymakers and planners identify weak pillars and target new programs accordingly; and researchers may use this in the longer-term to assess the predictive power of this new conceptual framework.
Challenges for patient-centred tuberculosis care in five hospitals in Indonesia

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ABSTRACT

Background: Achieving the best outcome for tuberculosis (TB) patients requires a patient-centred care approach. Delivering patient-centred care however is challenging for any healthcare facilities providing TB services, particularly in developing countries due to resources constraints and competing priorities. We aimed to assess key challenges for delivering patient-centred care in hospitals in Indonesia. Methods: A case study was conducted among three hospitals (two private and one public) at Jakarta and two hospitals (one private and one public) in Yogyakarta, Indonesia during year 2013. Data were collected by structured interviews of 75 adult TB patients using QUOTE (Quality of Care as seen through the Eyes of the Patient)-TB Light instrument to estimate the Quality Index (QI). The area of services with QI>1 was considered as the area needs for improvement. In addition, we conducted clinical audit of 149 medical records of TB patients and semi-structured interviews 7 medical doctors/nurses for triangulation. Results: Patients in general felt respected, experienced reasonable privacy and hardly any discrimination. However, they identified the need for improvement in areas related to: availability of services and facilities (e.g. availability of doctors, waiting time,), access to service (access of TB-HIV services, payment), care support (home care, contact tracing, food aid, transportation aid), and patient education (on treatment side effects, on TB-HIV). Our clinical audit data showed that none of the hospitals identified nor trained treatment supporters who are acceptable and accountable to patients. Interviews with health care providers confirmed that patient education practice has been lacking and contributed to treatment drop out. Discussion/Conclusions: We have identified major challenges for delivering patient-centred TB care in hospitals in Indonesia. Hospitals delivering TB services should address these challenges to ensure higher patient satisfaction, better outcomes and ultimately contribute to more effective TB control.
Successes, challenges and recommendations: perspectives from key informants on policy implementation to integrate HIV-care to primary health care clinics in Free State, South Africa

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ABSTRACT

Background: Many high-HIV burden countries are increasingly integrating HIV care into Primary Health Care (PHC) clinics to improve access to HIV treatment and strengthen people-centered health systems. However, little is known about successes and challenges of policy implementation in this context. This study aims to identify successes, challenges and recommendations made from a province-wide policy rollout of integrating HIV-care in PHC clinics, beginning in South Africa in 2010. Methods: Semi-structured, in-depth interviews were conducted with key informants (KI) in 2012-13 from the following health system perspectives: 1) Academic/Expert/Policy-Maker 2) Provincial Department of Health 3) District and Local Area 4) Clinic and 5) NGO. Initial participants were identified via purposive sampling and snowball sampling identified new participants until saturation. Interviews were conducted in English, audio-recorded and transcribed, then thematically coded using ATLAS TI. Deductive and inductive analysis led to new codes and emerging trends. Ethics approval was obtained and participants provided written-informed consent. Results: A total of 34 KI participated (2012:n=26, 2013:n=27), 19 of whom were interviewed both years. Successes were discussed in 4 themes: training, stakeholder/community engagement, additional clinic staff and political commitment. Nurse mentors, PALSA PLUS guidelines, financial and political support were seen as facilitators. Challenges were space and staff. Many participants discussed provincial policy roll-out moving faster than clinic capacities, unrealistic targets, insufficient drug delivery/forecasting, and insufficient managerial capacity. Recommendations included: applying lessons learned from HIV to PHC, increased coordination of provincial program managers, training personnel prior to policy implementation, engaging health care workers in policy rollout strategies, fast-track queues and providing 3 month drug supply to stable HIV patients. Discussion/Conclusion: A paradigm shift towards integrated HIV care is necessary to ensure strong, people-centered health systems in high HIV-burdened contexts. Understanding the successes, challenges and recommendations from a provincial policy implementation lens could inform the successful development and implementation of policies in similar contexts.
Two-way referral linkage patterns in obstetric and newborn care (ONC) facilities in selected districts of Bangladesh

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ABSTRACT

Introduction: An effective referral linkage is a pre-requisite for a functional health care system. Based on available literature, Bangladesh does not have a formal referral system in place. There are rare evidences of in-depth assessment of referral system in Bangladesh. The purpose of the study is to assess the current status of referral linkage among the obstetric and newborn care (ONC) facilities in selected districts of Bangladesh in order to identify gaps for strengthening of health system. Methodology: A health facility assessment was undertaken in 24 districts included 23 District Hospitals (DHs), 35 Mother and Child Welfare Centers (MCWCs) at district level, 158 Upazilla Health Complexes (UHCs) at sub-district level, 447 private for-profit (fp) hospitals and 89 private not-for-profit (nfp) facilities. Result: We found no systematic pattern for referring patients for maternal and newborn health complications. Referral from facilities was relatively low (In UHCs maternal referral 90%, newborn referral is 60%) in public facilities of sub-district level and private fp facilities (In pf, maternal referral 30%, newborn referral 40%). About 20%-40% of the public facilities and 60%-80% of private facilities do not provide referral notes regularly. The practice of regularly receiving referral notes is almost absent (DHs 3%, MCWCs 7%, pf 7%). Except 1/5th of private nfp facilities, the practice of two-way communication for referring patients is almost non-existence in regular manner. If informed by sending referral facility, except in UHCs, in all other facilities necessary actions are taken by the receiving facility in a reasonably acceptable manner. Discussion: There is a need to review existing policies for referring patients for maternal and newborn health complications. The country needs a policy for systematically referring patients from low to high level facilities. Effective two-way referral interaction between different levels of facilities needs to be further strengthened for proper management of complications.
Effectiveness of task-sharing between doctors and nurses on outcomes of non-communicable chronic disease management in primary care in South Africa: pragmatic cluster randomised controlled trial

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ABSTRACT

Background: Primary Care 101 is a clinical practice guideline providing an integrated approach to the primary care management of adults. We evaluated the effectiveness of on-site, case-based nurse training in the use of the guideline, coupled with additional prescribing provisions for nurses, on the management of non-communicable diseases (NCDs). Methods: This pragmatic trial cluster randomised 38 primary care clinics in the Western Cape Province. A total of 4393 patients were enrolled between March and October 2011: 3227 with hypertension, 1842 with diabetes, 1157 with chronic respiratory disease and 2466 screened positive for depression. Primary outcome measures were treatment intensification for the hypertension, diabetes, and chronic respiratory disease cohorts, and case detection for the depression cohort. Results: 3977 (90.5%) participants were re-interviewed at 14 months, and prescription information was obtained for 4280 (97.4%). Treatment intensification rates were high among participants with hypertension and diabetes, and similar between intervention and control groups (hypertension: 44.1% intervention group versus 40.3% control group, risk ratio (RR) 1.08 (95% CI: 0.94 to 1.24); diabetes: 56.5% v 50.3%, RR 1.10 (0.97 to 1.24)). Treatment intensification rates in those with chronic respiratory disease were similarly low in intervention and control groups (13.8% v 11.9%, RR 1.08 (0.75 to 1.55)). A pre-planned subgroup analysis showed higher rates of treatment intensification in moderately uncontrolled diabetic participants (baseline HbA1c 7-10%) in the intervention group (69.3% v 54.7%, RR 1.30 (1.16 to 1.47)). Case detection of depression did not differ between groups (17.9% v 23.9%, RR 0.76 (0.53 to 1.10)). Conclusions: Expansion of primary care nurses' role in the management of NCDs can be introduced safely. While superiority of the intervention on the primary endpoints for the four target diseases was not demonstrated, the treatment intensification in moderately uncontrolled diabetic patients suggests benefit of this training and task-sharing approach.
Tensions in redesigning primary care: practice clustering, mental models and hospitalization outcomes

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ABSTRACT

Background: Hospitalization is a sentinel event for older adults. Emerging evidence indicates that health system changes emphasizing patient-centered care can reduce hospitalizations. We aim (1) to explore sub-system variation in implementation and impact of patient-centered care and, (2) to explore two potential causes of that variation: (a) variation in employee mental models and (b) system tensions. Methods: 1-Within-system variation is explored via ANOVA of primary care providers’ (PCPs) way of practicing (via in-clinic observations). Cluster analysis formed six distinct PCP clusters. Patients’ ED utilization outcomes were calculated for each cluster and weighted using PSM. T-tests were used to assess score differences across clusters. 2a-Variation in Mental Models – Perspectives of University of Utah Community Clinics (UUCC) providers, and medical assistants (MAs) are explored (n=20). Five clinics were chosen to maximize contextual variation. Causal loop diagrams (CLDs) illustrating each participant’s view of the system were created. 2b-System Tensions – One overarching conceptual model for the system was created by integrating CLDs. Specific causal pathways were explored. Principal Findings: 1-PCPs practice differently across clinics, teams, and even teams in the same clinic (alpha=0.1). Six distinct clusters were generated. ED outcomes varied significantly across clusters (alpha=0.05). 2a- Variation in employees’ level of understanding of the system is evidenced by varying levels of ability to identify: 1) structures/parts, 2) tensions, and 3) causal mechanisms to explain those tensions. 2b-Causal pathways are presented for tensions any one individual only vaguely describes. Conclusions: 1-System-wide or clinic/team based analyses can mask underlying variation. 2a-Employees vary in their level of understanding regarding an intervention’s components and impacts. 2b-Bringing together mental models of those experiencing the system allows for elucidation of tensions.
Incorporating social franchising in government health services improves the quality of infant and young child feeding counseling services at commune health centers in Vietnam

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ABSTRACT

Background: While social franchising has been shown to enhance the quality of reproductive health services in developing countries, its effect on nutrition services remains unexamined. This study assessed the effects of incorporating elements of social franchising in shaping the quality of infant and young child feeding (IYCF) counseling facilities and services in Vietnam. Methods: Process-related data collected 12 months after the launch of the first franchises were used to compare randomly assigned A&T-supported health facilities (AT-F, n=20) to standard facilities (SF, n=12) across 3 dimensions of service quality: structure, process and outcome that capture the quality of facilities, service delivery, and client perceptions and use, respectively. Data collection included facility assessments (n=32), staff surveys (n=96), counseling observations (n=137), client exit interviews (n=137), and in-depth interviews with mothers (n=48). Results: Structure: AT-Fs were more likely to have an unshared, well-equipped room for nutrition counseling than SFs (65.0\% vs. 10.0\%). Process: Compared to SF providers, AT-F staff had better IYCF knowledge (mean score 9.9 vs. 8.8, range 0-11 for breastfeeding; mean score 3.6 vs. 3.2, range 0-4 for complementary feeding). AT-F providers also demonstrated significantly better interpersonal communication skills (score 9.6 vs. 5.1, range 0-13) and offered more comprehensive counseling sessions. Outcome: Overall utilization of franchises was low (10\%). A higher proportion of pregnant women utilized franchise services (48.9\%), compared to mothers with children 6-23.9 months (14\%). There was no quantitative difference in client satisfaction with counseling services between AT-Fs and SFs, but franchise users praised the AT-Fs for problem solving related to child feeding. Conclusions: Incorporating elements of social franchising significantly enhances the quality of IYCF counseling services within government primary healthcare facilities, particularly their structural and process attributes. Provided that service utilization is improved through demand generation, this model has the potential to impact IYCF practices and child nutrition.
Inequalities in routine immunization coverage in primary care: a multi-level mixed methods study from three Indian states

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ABSTRACT

Background: Immunization is key to prevent vaccine-preventable disease yet almost half of Indian children do not receive age-appropriate vaccinations. While individual and family level characteristics related to immunization uptake have been explored extensively, areas needing investigation include outreach services, vaccine supply and logistics, human resources issues and training, financing, and service delivery. Methods: We conducted an embedded multi-level mixed methods study exploring programmatic and beneficiary-level constraints in immunization, to understand the roles these factors are playing in immunization uptake. Methodological triangulation was conducted between a qualitative strand consisting of data collected from multiple levels of health care providers and beneficiaries, and a quantitative strand using structured questionnaires. The study was conducted in 11 districts of three states (Uttar Pradesh, Rajasthan, and Himachal Pradesh) from September-November, 2012. Results: Overall, vaccine supply was adequate. Mismatch in vaccine demand and supply, poor financial allocation for supplies and cold chain maintenance, human resource constraints (shortages and poor competencies), infrequent training and lack of monitoring and supervision, and inconsistent staff incentives, was hampering progress. Urban areas had special requirements due to lack of infrastructure, staff, and systematic mechanisms. Novel target setting, beneficiary estimations, and linking immunization to institutional delivery incentives showed marked improvements. National Rural Health Mission has contributed to improvement through financial and technical support, supplementing and supplying vaccines, consumables and cold chain equipment, and utilization of untied and flexible funds. Discussion: There has been significant progress in immunization in the states. However programmatic, financial, human resource and infrastructural challenges remain to improve access and quality of services. At the beneficiary level, societal biases, knowledge gaps, and increasing community's trust in the system, especially in those not accessing services, are important. Consistently, an increased level of awareness among the people for immunization and dedication and leadership from health staff were associated with better coverage.
Assessing satisfaction with care in Somalia: Preliminary results from health consortium for the Somali people project.

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ABSTRACT

Somalia has been without effective government for more than two decades. The DfID Health Consortium for the Somali people (HCS) project aims to increase the availability and utilization of basic health services. Our aim was to ascertain the client satisfaction with the services provided at the HCS funded facilities in Somaliland, Puntland and South-Central Somalia. We adapted questions from the Afghanistan Balanced Scorecard for the Somali context for the Client Satisfaction Survey. A local research organization was hired to implement the survey in a uniform manner in the three regions. Results: The mean age of the 750 women interviewed was 28 years, and the mean household size was 6.2 members. The average monthly income was US$154, and 54% had no education. Most visits were for ante-natal health (38%) or child health care (35%). 87% came on foot, and reported an average travel time of 35 minutes. The mean wait to see a health provider was 18 minutes. The health worker spent on average 12 minutes with the respondent, and the total cost of the visit averaged US$2.28. Most women (78%) were strongly satisfied with their overall visit. Satisfaction with different facility and worker characteristics ranged from a low of 62% (for ease of obtaining medicines at facility) to a high of 80% (for privacy during the visit). Discussion: This pilot project has demonstrated the feasibility of implementing a client satisfaction survey in a challenging environment, and has established a baseline against which future progress can be monitored. Valuable lessons have been learned that can help improve future surveys in Somalia.
Building an accountable and person-centered substance abuse treatment system in South Africa

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ABSTRACT

Introduction: In most developing countries, substance abuse treatment systems are underdeveloped and there is little information on the quality of services. Consumers’ voices are not included in the development of these treatment systems. The Service Quality Measures (SQM) project is the first initiative in a low and middle income country to develop a performance measurement system for substance abuse services aimed at improving quality of care. This presentation aims to critically review the development of the SQM initiative.

Methods: A national steering committee was formed to develop system goals, quality domains corresponding to each goal, and indicators for each domain. A Delphi exercise was conducted to refine the number of indicators based on the feasibility of developing measures for each indicator and the relevance and importance of these indicators to the local field. A decision was made to collect administrative data and consumer data that would inform service quality measurement. For the latter, we developed measures for the selected indicators that were pre-tested for comprehensibility and then subject to two rounds of pilot-testing to determine the psychometric properties of the measures. A toolkit was developed to support implementation and an initial evaluation of the implementation process has been completed. Results: Findings show that the service quality measures are easy to understand and that the measures contained in the survey are reliable and valid and easy to apply. The implementation has highlighted that the measures yield useful data and are easy to apply, but also suggest avenues where this performance measurement system can be strengthened.

Conclusion: Although the developmental stages of this initiative are complete, a lot still needs to be done to ensure that the system is implemented as planned and generates data that are used for quality improvement purposes. Several recommendations are provided to support appropriate implementation.
Diagnosis and referral practices of healthcare providers in regards to neglected tropical diseases related to persistent fever syndrome: an exploratory qualitative study in Eastern Nepal

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ABSTRACT

INTRODUCTION: Febrile illness is one of the most common reasons for seeking medical attention in Nepal. Infectious diseases associated with the persistent fever syndrome are on the increase. Both healthcare providers and patients face significant challenges regarding the diagnosis and clinical management of neglected tropical diseases, at rural health facilities. We conducted an exploratory qualitative study to better understand the current diagnostic and referral practices of healthcare providers related to the persistent fever syndrome at primary healthcare center. METHODS: We conducted an exploratory qualitative study consisting of sequentially organized observations, in-depth interviews and focus group discussions with healthcare providers. This study was implemented in primary healthcare centers and reference hospitals. Interviews and focus group discussions were recorded and transcribed. Data was analyzed using NVivo Qualitative Analysis Software (QSR International Pvt Ltd., Cardigan, UK). RESULTS: Healthcare providers were not overly familiar with the term persistent fever syndrome, although knowledge about associated symptoms and infectious diseases was good. Symptomatic treatment was mostly practiced at primary healthcare level, while reference hospitals employed a diagnostics-based approach. Limited diagnostic facilities and high volume of patients were some of the factors underlying limited diagnostic-based practices. No specific protocols were available for the diagnosis and management of Persistent Fever Syndrome. Only few Persistent Fever Syndrome patients seem to be referred to a higher-level for further diagnostic work-up and clinical management. Financial concerns, community beliefs and folklore and delays in seeking care were an important barrier to referral. CONCLUSION: An improved understanding of the current diagnosis and referral practices of healthcare providers is an important first step in developing and introducing new clinical algorithms. There is a perceived need for a clinical algorithm that would enable a systematic approach in diagnosis and case management of neglected tropical diseases with persistent fever syndrome at the primary healthcare level.
Admission rate and estimated expenses of Non-communicable Diseases (NCD) in Thai HIV infected population in universal coverage scheme

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ABSTRACT

Background: NCD such as diabetes mellitus (DM), chronic kidney disease (CKD) and cardiovascular diseases are an emerging healthcare problem not only for general public but also for HIV/AIDS infected patients. Purpose: To analyze burdens of NCD cares in hospitals between HIV/AIDS infected patients and non-infected patients by using two main indicators, i.e., admission rate (AR), and Adjusted Relative Weight (Adjusted RW) of Thai DRG to represent unit cost of care. Method: The retrospective cohort study using in-patient service databases of National Health Security Office (NHSO) between FY2006 and FY2013. In FY2013, there were 335,871 HIV infected patients and 48,612,007 non HIV infected patients under the UHC scheme. NCDs are defined by the 2010 WHO diagnosis. The unit of AR was per 100,000 of population. Reimbursement rate for each of an Adjusted RW was at about THB 8,000. Results: In HIV/AIDS infected patients, the trends of AR were increased in DM (13.79-87.07), hypertensive disorder (HTN) (6.89-38.05), CKD (2.51-55.08), chronic obstructive pulmonary disease (COPD) (10.07-63.62), lymphoma cancer (6.78-38.11), and ischemic heart disease (IHD) (2.51-63.42). However, the AR in asthma was increased at the beginning then dropped thereafter. Comparing with non HIV/AIDS infected patients, these were increased in DM (180.34-205.43), CKD (40.25-77.76), lymphoma cancer (5.57-8.00), IHD (88.42-125.16). However, the AR in HTN was decreased from 142.03 to 122.10. In HIV/AIDS infected patients, the Adjusted RW of lymphoma cancer, IHD, CKD, HTN, COPD, DM and asthma were 3.8234, 2.5911, 1.8223, 1.4019, 1.1172, 0.9827 and 0.5891, respectively. These were closely to another group. Conclusions: The AR of most of the NCD in HIV/AIDS infected patients were less than non HIV/AIDS infected patients except in lymphoma cancer which extremely increased in HIV/AIDS infected patients.
Impacts beyond primary outcomes: A mixed-methods study exploring multiple perspectives of a health system intervention in Eastern Uganda

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ABSTRACT

Background Interventions aiming to improve health systems should engage people on the frontlines of healthcare delivery. The PRIME intervention was designed to build health workers' (HWs) skills by supporting and motivating them emotionally at work with the goal of improving treatment and attracting patients to health centres (HC) in Eastern Uganda. We conducted a cluster-randomised trial (CRT) to evaluate the impact of PRIME on population-level health outcomes and a mixed-methods study to examine PRIME from the perspective of HWs and patients enrolled in the trial. Methods Ten HCs were randomized to the intervention and 10 to control with primary health outcomes measured in community-level clusters over two years. Mixed-methods included 306 HW communication assessments, 10 HW interviews, 13 community member focus groups, and 1200 patient exit interviews. These methods sought to explore HWs’ interpretation and enactment of the intervention, and community members' and patients’ satisfaction and perceptions of change related to PRIME. Results Post PRIME implementation, interpersonal communication was rated 10% higher (p<0.008) by patients consulting with HWs in intervention HCs. HWs reported that improvement of technical skills and use of new technologies had a positive effect on feelings of professionalism and patients’ positive feedback. However, HWs reported feeling unsupported and demotivated due to increased workload, and poor recognition, payment and supervision. Patients and community members reported increased satisfaction at some PRIME HCs, but also highlighted other areas of HCs needing improvement. Discussion Despite a lack of significant effect in the population-level primary health outcomes, this mixed-methods evaluation revealed additional impacts including benefits, consequences, motivations, and interpretations of PRIME from the perspective of people who are central to the health system PRIME was intending to change. We will discuss what can and cannot be achieved and brought to light through a CRT model of evaluation of people-centred health system interventions.
Is institutional delivery seasonal? multilevel analysis of longitudinal data from Rufiji district of Tanzania

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ABSTRACT

Background For proper care, delivering at a health facility is fundamentally encouraged as a single most important strategy in preventing maternal and neonatal deaths. Although several studies have assessed factors affecting place of delivery, the role that seasonality plays in this case is unknown. Methods This study uses longitudinal data from the Rufiji Health and Demographic Surveillance System (HDSS) in Tanzania from 2007 -2010. All births with complete information on where they occurred, as well as their corresponding maternal and household characteristics were extracted from the HDSS database for the current analysis. Bivariate analysis with a Chi-square test was performed and finally multivariate multilevel analysis was conducted. In the multivariate analysis, we assumed that births are nested within woman (i.e. place of births of the same woman are dependent) and also that women are nested within villages (i.e. women who reside in the same village may share same behaviors). Results Overall 74.5% of all 7,244 deliveries recorded by the Rufiji HDSS from 2007 to 2010 occurred in health facilities. While facility delivery was 72.7% during heavy rains, so was 75.7% during dry or less rains. In multivariate analysis, the odds of facility delivery was significantly 35% higher during dry or less rains compared to that of heavy rains (odds ratio (OR)=1.35, 95% confidence interval (CI) 1.08-1.68). The ICC was 38.7% and 16.2% for mothers and the village respectively. Factors controlled for were household socioeconomic status, distance to the nearest health facility, maternal age, marital status of the mother, maternal education, parity, maternal occupation, and calendar year. Conclusion Facility delivery in Rufiji district is seasonal, with a small but significant better access during dry or less rains. The Tanzanian health system needs improvements to adequately respond to all barriers that limit access to institutional delivery care during heavy rains.
Human resources at the core of strengthening people centred health systems: Health workers' experiences and understanding of a quality improvement intervention for maternal and newborn care in rural Tanzania

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ABSTRACT

Background Quality improvement approaches are increasingly promoted to strengthening health services and systems in rural Sub Saharan Africa. Such initiatives need to be people-centred to fit the needs and education level of the health workers implementing them. EQUIP (Expanded Quality Management Using Information Power) is an EU-funded, collaborative quality improvement intervention for maternal and newborn care, implemented in Tandahimba district, south-eastern Tanzania, in 2011-2014. With the overarching aim to investigate feasibility of this approach, including the use of Plan-Do-Study-Act (PDSA) cycles and run-charts to monitor progress in rural health facilities, we explored health workers' understanding and experience of working with EQUIP.

Methods We conducted 17 in-depth interviews with health workers of different cadres in the district hospital, all health centres and 10 of the 28 dispensaries. Interviews were conducted in Swahili, transcribed verbatim and translated into English. Data was analysed using qualitative content analysis.

Results Preliminary results indicate that health workers felt motivated by the regular follow-up from the EQUIP team. Many health workers had discovered new responsibilities e.g. in encouraging mothers to prepare for birth and to deliver in health facilities. New knowledge, especially on resuscitation of newborns, had been well received and applied by several health workers. Understanding and implementation of PDSA cycles and run-charts varied however, with poorer understanding and implementation among lower level cadres of health workers. Discussion/conclusions Health workers' appreciation of regular follow-up and focus on problems in every day practice resonates well with previous experience of mechanisms for strengthening quality of care in rural contexts. The quality improvement approach as implemented by EQUIP may however benefit from adaptation for use with health workers of lower cadres. This could have the potential of making it more people centred and increasing health worker understanding and implementation.
Can devolved health service delivery work in Kenya? evidence from the Public Expenditure Tracking and Service Delivery Indicators (PETS-Plus) Survey, 2012

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ABSTRACT

Background: The new constitution of Kenya (2010) assigns the larger portion of service delivery responsibility to new county governments. Fulfillment of this responsibility depends on the resources at the disposal of these devolved structures, such as the distribution of health inputs and the numbers and capacities of health providers. Methods are urgently needed to inform the capacity of devolved/decentralized levels to implement ambitious health targets across Africa, especially in Kenya. Methodology: In 2012, the USAID-supported Health Policy Project, in collaboration with the Ministry of Health, the Kenya Institute for Public Policy Research and Analysis, and the World Bank, modified and merged the previously available methodologies of Public Expenditure Tracking Surveys (PETS) and Service Delivery Indicators (SDI) Surveys. The combined ‘PETS Plus’ provided integrated financial and health system data on devolved government capability by sampling a set of counties and health facilities therein, both public and NGO/FBO. The survey assessed the availability of key inputs (drugs, equipment, infrastructure, etc.) as well as the numbers of health workers, their absenteeism levels, and knowledge on the management of key interventions (using clinical vignettes). Results: The data reveal major gaps in the health workforce, as demonstrated by high levels of sanctioned/unsanctioned absenteeism, and lacks in provider knowledge and skill. Key tracer drugs for maternal healthcare were inadequately available. Enforcement of key government policies on user fees was weak. If not addressed, these issues augur poorly for quality and accessibility of health care services provided by county-managed health facilities. Discussion/Conclusion: Many sub-Saharan African countries plan to devolve responsibility for health services. Urgent information is needed from targeted surveys that can lead to policy action and rational allocation of resources. Our approach using the combined PETS Plus 2012 survey suggest how governments can focus on improvements in distribution and ability of the health workforce, commodities, policy implementation, and equipment.
Strengthening primary care to improve health system effectiveness and responsiveness: The introduction of family medicine in Turkey

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ABSTRACT

Background: Strengthening Primary healthcare (PHC) is a global priority. Whilst seen to improve health system effectiveness and responsiveness, country-level evidence supporting this view is limited. Turkish PHC reforms, which included direct contracting arrangements, performance-based incentives, and improved training and guidelines, provide a unique setting for PHC evaluation. Step-wise introduction of Family Medicine (FM) across 81 provinces presented a natural experiment. This study evaluates the impact of FM introduction on healthcare utilisation and user satisfaction.

Methods: Administrative data on annual consultations, health facilities and physicians was obtained from the Turkish MoH for 2005-2011. User satisfaction with services was available from the Turkish Statistical Institute's nationally representative Life Satisfaction Surveys. The impact of FM introduction on health care utilisation was assessed with multivariate regression adjusting for supply-side variables, demographic characteristics and underlying yearly trends. Trends in preferred healthcare provider, reason for choice and health services issues, were described and stratified by patient characteristics, provider type, and rural and urban settings. Results: Over 2005-2011, PHC consultations increased from 1.76 to 3.13 per person. FM introduction was associated with an increase of 0.21 PHC consultations per person in multivariate models (p<0.001). While the ratio of primary-to-secondary consultations remained at 38%, FM introduction was associated with a 3.4% shift from secondary to primary care (p<0.001). PHC increased as preferred provider by 9.5% over 7 years with the reasons of proximity and service satisfaction increasing by 14.9% and 11.8% respectively. Reporting of poor facility hygiene, difficulty getting an appointment, poor physician behavior and high costs all declined (p<0.001) but remained higher among urban, low income and working-age populations. Conclusion: Expanding PHC through the introduction of a comprehensive new service arrangement appears to have increased utilisation and satisfaction in Turkey. Policy-makers in LMIC settings considering PHC strengthening may expect tangible improvements to health system effectiveness and responsiveness.
Are there any differences in perceptions of quality of care between patients and health care providers in Ghanaian hospitals?

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ABSTRACT

Background Ghanaians increasingly raise concerns about the quality of health care in hospitals, in the wake of increased utilization of health services thanks to the national health insurance scheme. Much study has been conducted on perceptions of quality of care by patients, in both developed and developing countries. However, less study is done comparing the perceptions of quality between patients and service providers. This study sought to fill this gap. Methods Three regions, namely, the Upper East, Brong Ahafo and central regions, were selected for the study. A total of 818 out-patients and 152 top and middle level managers from 17 hospitals were selected by convenience and purposive sampling strategy respectively for interview. The hospitals included public, mission and private ones. T-test statistic was used to test for differences in perceptions of quality between patients and health care providers. Results The results show that of the 24 indicators assessing quality of care, 19 (79%) indicate a significant difference in perceptions of quality of care between patients and health care providers, with the latter tending to rate quality of care more favourably. Among others, the key indicators showing significant differences include: affordability of cost of care, fairness to all patients regardless of insurance status, adequacy of doctors, waiting time, availability of doctors, patients' involvement in their care and showing compassion and support. Discussion/conclusions It is not unexpected, that health care providers would award themselves higher scores compared with patients. However, where the difference is significantly marked, it should be a matter of concern, since this may indicate a wide gap between the quality expectations of patients and providers. Further studies are required to explore reasons for these gaps. This study is significant in the area of strengthening quality of care, in view of the importance of quality care to the success of the national health insurance scheme in Ghana.
Health system gaps in the management of childhood TB in Bangladesh: findings from a rapid assessment

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ABSTRACT

Background: According to the Bangladesh National Tuberculosis Control Program (NTP), the proportion of childhood TB among all reported cases is 2.8%. This is considerably low compared to other high-burden countries. Contrary to NTP estimate, studies conducted by the Damien Foundation and icddr,b have shown a far greater burden of childhood TB in Bangladesh. For understanding the causal factors behind low case detection, we conducted a rapid assessment supported by USAID during April- August 2011 at selected primary healthcare facilities to identify gaps in childhood TB management in terms of supply-side inputs, processes and outputs, and identify modifiable determinants of gaps pertinent to capacities and resources.

Methods: Nineteen primary healthcare outlets were purposively chosen from urban and rural areas. Key informant interviews, facility inventories, review of service statistics and documents were conducted. Information collected was organized by manual coding into themes and sub themes for thematic analysis. Triangulation of data derived from different sources was carried out to validate information.

Results: Proportion of childhood TB managed was substantially low (4%) compared to adult TB cases (96%). No case of TB was detected in under-five children. In Dhaka, children were diagnosed at the tertiary-care facilities and showed up at study clinics for receiving anti-TB drugs. Service providers had no training on childhood TB management depicting a knowledge gap. The IEC materials displayed and used were focused on adult TB. Shortage of supplies for Mantoux test and radiology was observed. Contact tracing and preventive therapy were not routinely practiced.

Conclusions: Considerable gaps in the capacity of workforce, information dissemination, and diagnostics were identified. Determinants attributable to gaps were lack of training, IEC materials specific to childhood TB, and diagnostic tools. Based on the hypothesis generated through this assessment, we recommended undertaking of an ongoing implementation research to develop, test, and scale up appropriate interventions.
Evidence use and health systems reform in Colombia

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ABSTRACT

Background In the context of rising costs of the healthcare, and debates around universal health coverage, Colombia is attempting to reform health system. This represents the culmination of a decade long attempt by the current and previous administrations to reform the 1993 health insurance system. The current reforms have become the site of great political contestation between different health systems and policy actors (insurers, service providers, doctors’ associations, government officials, public health advocates and sectoral trade associations). In the context of these highly politicised reforms, the current paper investigates the use of evidence to inform policy deliberations. Methods The study employs documentary analysis and a series of semi-structured interviews with key policy actors, including Ministry of Health officials, representatives of professional bodies and trade associations linked to the current debates. Interviews were recorded, transcribed and analysed by the current authors. Results A wide range of evidence of relevance to the current debates emerges from a range of sources and in a range of forms including statistics on health indicators and health service performance produced by government agencies; national health surveys; academic studies and reports by health policy actors (including service providers, insurers and industry actors). Fault lines in the debates emerge over both the model of health system (insurance based v national health system) and the level of health coverage provision within the context of a constitutionally enshrined right to health services. Discussion Decisions on key health reform issues are highly politicised, which impacts on the use evidence to inform current debates. Questions arise about both the quality of the evidence produced and the capacity of the government to gather process and interpret this evidence. The level of contestation impacts on the ability of policy actors to make evidence informed decisions.
Evidence use and health systems stewardship: Contributions from an institutional analysis perspective

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ABSTRACT

Background Contemporary discourse around the use of evidence in policy typically frames the issue as one of increasing knowledge uptake. However, there has been increasing awareness that getting research into policy is not only a technical matter of knowledge translation and exchange, but also a political challenge.

Methods Our discussion proposes an alternative understanding of 'evidence informed' health policies based on the use of a new-institutional methodological approach. As part of the GRIP-Health project, our contribution builds on initial findings from empirical analysis completed to date on a set of country case studies in low, middle, and high income countries about the usage of research evidence in health policymaking.

Results By providing a new lens to investigate the effectiveness of health governance and evidence use, institutional analysis has great potential for contribution to system analysis. This contribution lies in giving specific sense to system analysis' idea that 'responsibility replaces objectivity' (Ison) by illustrating how the 'stewardship' of Ministry of Health guiding health systems functioning connects to the way formal and informal institutions shape the process of evidence use.

Discussion As much as 'responsibility replaces objectivity', technical and political responsibility on health decisions relies also on non-evidentiary criteria. Not only policymaking involves tradeoffs between multiple values as well as contingency decisions about the selection of particular pieces of evidence; but more specifically, evidence is processed into an institutional framework which responds to specific principles of system functioning. This institutional framework is made of political structures, bureaucratic arrangements, formal and informal rules, social expectations of subordination between government and citizens. We propose here to discuss our initial findings on how political institutions support or hinder idealised concepts of evidence use for health policy making, while raising preliminary judgments on whether institution-specific processing of evidence is effective in terms of policy decisions.
Political and institutional determinants of the limited roll-out of user fees exemptions for the elderly in Senegal

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ABSTRACT

Background: Analysis of Social Health Protection (SHP) programmes' effectiveness often fails to capture the causal roots of observed patterns. Exploring the political and institutional contexts in which SHP programmes come into being can help identify determinant factors for the success/failure of these interventions. Adopting this perspective, this study seeks to understand underlying causes of the insufficient implementation of Plan Sesame, a user-fee exemption scheme for older people in Senegal launched as a presidential initiative in 2006. Methods: Results of a large-scale household survey conducted among 2,933 households in 2012 were triangulated with a policy analysis, which employed qualitative material collected through literature reviews, policy documents analysis and inductive coding of 56 stakeholder interviews. Results: The survey confirmed that, among eligible beneficiaries, less than 5% of those who had need to access healthcare services were effectively exempted in 2011. We relate these findings with the hasty development of the Plan within the context of an electoral campaign. This impacted the Plan's implementation: put into place quickly, differing to the original design and lacking clear allocative funding. In addition, while decrees were passed, most of the bodies in charge of Plan Sesame had not been established. Plan Sesame reveals a lack of consensus among stakeholders and was not strongly supported by key organizations such as health providers and donors. Subsequent patchy implementation has allowed a form of implicit rationing to take place, with socially excluded older people being less likely than the socially privileged to access the scarce resources made available by the government. Conclusion: The research suggests that hasty policy development in the context of an electoral campaign can enhance rather than reduce inequities in access to health services. Nevertheless, a window of opportunity may be presented in such contexts, providing a springboard for more effective policy development and implementation.
Early summative evaluation of a quality improvement learning collaborative aiming to reduce mother-to-child-transmission of HIV in South Africa

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ABSTRACT

BACKGROUND: We report on a quality improvement learning collaborative underway across 39 demonstration sites in South Africa. The objective of the collaborative is to operationalize the South African government National Action Framework for No Child Born with HIV by 2015 & Improving the Health and Wellbeing of Mothers, Partners and Babies in South Africa. The overall aim of the collaborative is to decrease mother-to-child transmission of HIV to below 2% at 6-weeks postnatal, and to below 5% at 18-months postnatal. METHODS: A concurrent triangulation mixed methods research approach was followed. Data sources included routinely collected program data, focussed baseline assessment of participating facilities, quality improvement maturity survey of participating health workers, and health outcome data routinely reported by facilities to the District Health Information System. A time series analysis of internal and external control groups within the study context was utilized to elicit understanding on dose-response relation between intensity of the Collaborative interventions and to allow comparison of data with similar facilities that have not participated in the Collaborative. RESULTS: The collaborative consists of 6 Action Periods distributed over 22 months that aims to systematically test and document improvement interventions along the EMTCT processes of care. The collaborative network included 39 primary healthcare facilities distributed across 3 provinces. The first 3 months of the collaborative addressed antenatal processes of care and we were able to document a sustained improvement in early antenatal booking in 2 of the participating sub-districts, corresponding with collaborative interventions. A surprising finding was high levels of maturity in quality improvement organizational culture among facilities not previously exposed to formal quality improvement training or collaboratives. CONCLUSION: Lessons learnt during the early summative evaluation of this demonstration collaborative will inform both program implementation theory and program effect theory for the planned scale-up of QI interventions.
After achieving the millennium development goal No. 5, what's next?

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ABSTRACT

Introduction: Maternal Mortality Ratio in Egypt as reached 62 in 2010, down from 230 in 1990. This means that Egypt has achieved MDG No. 5 (reducing maternal mortality ratio by three quarters), at the national level. However, gaps between the different regions of the country still exist. Moreover, it's unclear what should be the country strategy to sustain this accomplishment. This paper examines the reproductive healthcare system status in two of the main southern governorates in Egypt, to identify how prepared are the health facilities there to sustain the already achieved success in reducing maternal mortality ratio and to reduce the inequality gap, through strengthening the monitoring system for service delivery and promoting evidence-based decision making. Methodology: This is a mixed methods research, where both quantitative and qualitative data is collected at the designated governorates. The quantitative part includes data at health facilities, such as available resources, available personnel, medical qualifications of the personnel, and the status of the currently operating health information management and quality assurance systems. The qualitative part includes conducting in-depth interviews with key informants at governorate level and focus group discussions at the district level to assess the managerial skills, and the status of the currently operating health information management and quality assurance systems, at the supervisory level. The mixed methods technique will provide in-depth insights and triangulation of data pertaining to health information management and quality assurance systems. Data will be used to assess technical efficiency of the health system in these governorates, and identify the gaps to fully achieve MDG No.5 Results: The authors expect to find a myriad of potential areas for improvements, to improve system efficiency and fully achieve MDG No.5. Conclusion: It's remarkable to achieve MDGs at the national level, but it's not the ultimate goal. It's equally important to sustain the accomplishment and continue the efforts to reduce health inequality at the regional level.
Inclusion of private sector in district health systems; case study of private drug shops implementing modified integrated Community Case Management (iCCM) strategy in rural Uganda

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ABSTRACT

Background: Uganda Ministry of Health passed the Public Private Partnership for Health (PPPH) policy to strengthen the health system by leveraging strategic advantages of private healthcare providers. Makerere University partnered with Mbarara district to implement the iCCM strategy in private licensed drug shops in rural areas. The partnership aimed to improve care for child febrile illnesses, minimize excess use of antimalarials and antibiotics, and integrate private drug shops into district health systems. Methods: This was a plausibility design study with baseline and end-line assessments in the intervention and comparison districts. The intervention was introducing modified iCCM strategy at licensed drug shops in the rural Mbarara district. This involved training the drug shop attendants on how to manage febrile illnesses in under-fives using the standardised sick child job aid, supply of subsidized medicines and diagnostics, integration of drug shop health information system with district HMIS and routine support supervision. Qualitative interviews to explore views, attitudes and perceptions of various stakeholders and wider health systems effects of intervention are ongoing. Ethical approval was sought and granted. Results: Baseline surveys show that drug shops provide care to over 50% of child febrile illnesses in rural Uganda. 96 drug sellers were trained and hence 69 drug shops in rural counties of Mbarara district are implementing the modified iCCM strategy. Continuous monitoring and support supervision has started to explore how private drug shops can be integrated into the district health system. Drug seller performance and attrition, linkages with nearest public health facility and monthly reporting on HMIS indicators are being examined. Conclusion: Private drug shops provide healthcare to under-five febrile children as first point of contact in rural areas. Their recognition and integration into district health systems will increase penetration of life saving interventions especially for the most vulnerable populations. Significance: It evaluates quality improvement strategies while increasing access to quality medicines and diagnostics for under-five patients.
Deploying a health system and supporting teams to reduce stockouts among community health workers in Malawi

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ABSTRACT

Background: A 2010 assessment of the community health supply chain in Malawi identified poor logistics data visibility and limited responsiveness to stockouts as barriers to product availability among CHWs. SC4CCM designed the Enhanced Management (EM) intervention, which combines cStock, a mobile health reporting and resupply system, with a team approach for using data for performance improvement, to increase availability of health products among CHWs. This paper presents preliminary findings on the utilization of EM and changes in stockouts of essential drugs. Methods: The effectiveness of EM in reducing stockouts and strengthening key supply chain processes was assessed through (a) routine data, (b) qualitative focus groups and (c) quantitative surveys administered at baseline (2010; n=248) and midline (2013; n=249) across study arms. Routine data consisted of cStock dashboard reports; focus groups with HC staff and CHWs that sought to determine perceptions of EM; quantitative surveys captured supply chain indicator data at district, HC and CHW levels in 10 districts. Results: Focus group findings suggest that adoption of EM was feasible and acceptable for reporting, resupply and supply chain management. Routine data collected from May 2012 to February 2013 indicate that over 90% of CHWs reported logistics data to cStock every month. In health facilities surveyed, 92% of Drug Store in-Charges used cStock data for resupply decisions, and more than 70% of health center staff reported holding team meetings in the last three months. Survey findings suggest that supply chain outputs improved in EM districts: time between reporting and resupply was reduced by 50%, and CHWs had 14% fewer stockouts or low stocks. Conclusions: EM proved to be feasible and acceptable to users at all levels, and effective for improving key supply chain performance indicators. cStock improved availability of timely information and team work improved use of data for decision making.
Prioritizing secondary care: onehealth application to the health sector in Mozambique

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ABSTRACT

Background: Cost projections are increasingly important for implementation and resource mobilization plans related to national health strategies. Within this field, approaches to cost sub-Saharan secondary healthcare systems have been limited. In Mozambique, the government is embarking on the Health Sector Strategic Plan 2014–2019 (PESS). The USAID-funded Health Policy Project (HPP) in collaboration with the Ministry of Health estimated the cost of the PESS, including the secondary healthcare sector. Methodology: We used the OneHealth tool, an innovative health systems strategic budgeting approach based on WHO health system building blocks. We developed additional tools for the cost analysis of secondary health programs, involving drugs and commodities and programmatic management costs, such as for in-service training, coordination, etc. In order to appropriately cost secondary healthcare services, we projected numbers of future patients reached for each secondary, hospital-based curative program, e.g. internal medicine, in terms of reported outpatients, inpatients, and surgeries. Based on our literature review, costing techniques we developed are unprecedented for the detailed analysis of secondary, hospital-based services at the sector level for sub-Saharan Africa. Results: Over 2014 - 2019, secondary healthcare in Mozambique, not including HIV treatment, prevention, or circumcision, will require US$1,204 million in constant 2013 dollars, and represent 15% of the total PESS costs. Most of these costs derive from the internal medicine program (US$498 million), followed by the central laboratory services (US$104 million). Discussion: The cost of the secondary healthcare programs in Mozambique is significant, though likely underestimated due to a lack of data on patient targets. Estimates of disease burden and scale-up targets for secondary healthcare services are needed to mobilize resources for the health sector. Wide-sharing of our costing approach will help improve access to essential medicines in this critical sub-sector as Africa’s secondary healthcare programs expand to meet rising non-communicable and other disease burdens.
Employing the lot quality assurance sampling system to track Community Health Workers (CHWs) follow up activities in a rural district of Zambia.

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ABSTRACT

Background: The Better Health Outcomes through Mentoring and Assessment (BHOMA) project is a cluster randomized controlled trial aimed at reducing age-standardized mortality rates in rural districts through community involvement of Community Health Workers (CHWs), Traditional Birth Attendants (TBAs) and Neighborhood Health Committees (NHCs). CHWs undertake quarterly surveys on randomly selected households in order to complete a questionnaire of key health events within their catchment populations. Here we report experiences using the LQAS for tracking and validating CHW contacts with households and key outcomes from the surveys in Luangwa district.

Methods: Between April 2011 and December 2013, seven health facilities and their populations were enrolled to the BHOMA project. For each site, identified CHWs were trained through protocols, fieldwork and electronic data systems. Quarterly, 19 randomly selected households representing 2/3 of the zones in each health center (or all zones for the health centers with less than six zones) are sampled. Quarterly CHWs visited each household in their zone to collect data on births, illnesses, and deaths, provide health education, and promote health-seeking behaviors. We expected CHWs to conduct at least 75% of this work in order for them to meet their target.

Results: A total of 36 CHW were engaged and on average 4,616 households visited every quarter. 7 survey rounds were undertaken representing a total of 4,123 household visits. Findings of LQAS were that over 75% of zones in the district 'passed.' In zones where the number of positive responses was < 15 (i.e. zone did not pass) remediation with the respective CHW was undertaken. Conclusion: Our experience confirms that LQAs methodology can be employed to confirm household visits by CHW and identify poor performing CHWs. It remains to be seen whether CHW engagement as BHOMA project has done would result in health impact on morbidity and mortality.
TB management and discharge planning experiences of nurses in a central academic hospital, Cape Town - a qualitative study

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ABSTRACT

Background: Ensuring quality and effective clinical management and continuity of TB care across hospital and Primary Health Care (PHC) services remain challenging in South African public healthcare settings. The study investigated the inpatient management and discharge planning to PHC services of patients with TB from the perspectives of healthcare staff at a central academic hospital. Methods: Applying a participatory research approach, semi-structured focus groups were held with a total of 47 nurses, seven ward clerks and six medical interns. The qualitative data was analysed using the Miles and Huberman approach, and the emerging themes verified by two researchers. Results: Key emerging themes were: inadequate TB education and support for patients, healthcare worker fear of TB infection, poor discharge processes, and a lack of service communication and coordination between hospital and PHC levels. Conclusion: Systems and tools are needed to improve the quality of patient management and education, the discharge process, and communication and care coordination between hospital and PHC services. Findings from the study are being used to inform the planning of such interventions to improve and monitor the quality and continuity of TB care.
Essential medicines procurement in six Indian states: a comparison of centralized and decentralized procurement systems.

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ABSTRACT

Background: Provision of safe and effective medicines to patients is a central goal of public health systems, and key for sustaining access to quality health care. Indian states have adopted centralized (at headquarter) or decentralized (at district) levels of medicines procurement. These models differ in budgetary allocation, tendering, supply chain, and distribution systems. Outcomes like drug availability and stockouts can indicate availability, accessibility, and quality of care. Methods: Data on median availability and days of stockout (over last 6 months) of essential drug list (EDL) medicines were collected across 61 districts between late 2009 to September, 2013, from 411 public health facilities, using structured questionnaires. Two states (Tamil Nadu and Kerala) with centralized and four states (Bihar, Haryana, Punjab, Uttar Pradesh) with decentralized procurement systems were contrasted. Indicators were analyzed across therapeutic categories and appropriate availability at primary (PHC) and community health centers, and district hospitals. Results: EDL availability varied from a low of 33.4% in UP to 57.4% in Kerala to 87.8% in TN, with majority of states ranging between 40-50%. Highest EDL stockouts were found in Bihar (41.3%), with Kerala reporting 7.3%. Average duration of stockout was highest in Kerala. Vitamins, antibacterials and anti-allergic drugs were present in less than half of PHCs. Analgesics, ORS, uterotonics and anti-hypertensives were in overall short supply. Only one-third of PHCs had stock of anti-diabetics, antidepressants/antipsychotics and anti-asthmatics, with highest availability in Kerala. Across all states except Punjab, district headquarter facilities fared better than PHCs. Discussion: Strengthening medicine procurement and supply chains are imperative for universal access to high quality medical care. While states with pooled procurement had overall higher availability of drugs, higher duration of stockouts indicates room for improvement. Inefficiencies and poor availability in decentralized procurement models suggest that pooled procurement mechanisms can increase access to essential medicines.
The effect of health facility delivery on neonatal mortality: systematic review and meta-analysis

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ABSTRACT

Background: Though substantial progress has been made towards achieving the millennium development goal four through remarkable reduction in under-five mortality, the decline in neonatal mortality remains stagnant, mainly in the middle and low-income countries. As an option, health facility delivery is assumed to reduce this problem significantly. However, the existing evidences show contradicting conclusions about this fact, particularly in areas where enabling environments are constraint. Objective: To determine the pooled effect of health facility delivery on neonatal mortality. Methods: The reviewed studies were accessed through electronic web based search strategy from PUBMED, Cochrane Library and Advanced Google Scholar by using combination key terms. The analysis was made by using STATA-11. I² test statistic was used to assess heterogeneity. Funnel plot, Begg's test and Egger's test were used to check publication bias. Pooled effect size was determined in the form of relative risk in the random-effects model using DerSimonian and Laird's estimator. Results: A total of 2216 studies conducted on the review topic were identified. During screening, 37 studies found to be relevant for data abstraction. From these, only 19 studies fulfilled the preset criteria and included in the analysis. In 10 of the 19 studies included in the analysis, facility delivery had significant association with neonatal mortality; while in 9 studies the association was not significant. Based on the random effects model, the final pooled effect size in the form of relative risk was 0.71 (95%CI: 0.54, 0.87) for health facility delivery as compared to home delivery. Conclusion: Health facility delivery is found to reduce the risk of neonatal mortality by 29%. Expansion of health facilities, fulfilling the enabling environment and promoting its utilization during child birth is essential in areas where home delivery is a common practice.
Does performance based-incentive for health care providers improved maternal and neonatal health care?: results from quasi-experimental study in rural health districts in Burkina Faso

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ABSTRACT

Background Performance-based incentive is currently receiving increased attention as a strategy for improving the performance of health care providers. This study funded through EU-FP7 program aimed to assess the effects of tailored incentive for health workers on maternal and neonatal care quality and coverage. Methodology A Quasi-experimental study was undertaken in two rural health districts presenting similar characteristics. The study had an intervention and a control arms with the intervention receiving the incentive package while the second arm serves as control. Baseline performance indicators were collected before and after the intervention. Incentives were provided over two year period to health providers in the intervention area. The effect was measured using quality composite score and selected health routine indicators from 12 health facilities. Statistical analyses using a t-test for two independents variables to measure the effects of the intervention based on difference-of difference method in Stata 11 . Pearson test was performed to explore potential correlations between the different predictors and outcome variables. Results The control and the intervention health districts presented similar baseline performance indicators in 2010, (p-value=0.87; 95% CI: [60.46; 67.08]) Overall, performance indicators improved in the intervention arm as compared to the control in 2012 (p-value <0.001; 95% CI: [62.65; 74.85]. However the intervention seems to have no direct impact on some key immunization coverage indicator such as BCG and polio. Pearson test shows positive correlations between distance to health facilities (>5 km) and ANC4, Assisted delivery, but not statistically significant (r=0.07; P=0.41). The difference in quality score between the two arms is statistically significant (p= 0.03, 95%CI: [-20.42; -4.57] Conclusion Although paying health worker for performance is a new paradigm introduced in health system financing, evidence shows it does not directly impact on some key performance indicators.
Acceptability and feasibility of using non-specialist health workers to deliver mental health care: stakeholder perceptions from the prime district sites in Ethiopia, India, Nepal, South Africa, and Uganda

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ABSTRACT

Background Three-quarters of the global mental health burden exists in low- and middle-income countries (LMICs), yet the lack of mental health services in resource-poor settings is striking. Task-sharing (also called task-shifting), where mental health care is provided by non-specialists, has been proposed to improve access to mental health care in LMICs. Methods This multi-site qualitative study investigates the acceptability and feasibility of task-sharing mental health care in LMICs by evaluating perceptions of primary care service providers (physicians, nurses, and community health workers), community members, and service users in the five countries participating in the PRogramme for Improving Mental health careE (PRIME): Ethiopia, India, Nepal, South Africa, and Uganda. Thirty-six focus group discussions (n=265 participants) and 164 in-depth interviews were conducted between February and October in 2012 across these five country sites with the objective of developing a model of mental health care integrated into primary care. Acceptability and feasibility of task-sharing were evaluated first at the country level through open-coding and then at the cross-country level through a secondary analysis of emergent themes at the country level. Results We found that task-sharing mental healthcare services is perceived to be acceptable and feasible in LMICs as long as key conditions are met: 1) improved access to human resources and medications; 2) ongoing structured supportive supervision at the community- and primary healthcare-levels; and 3) adequate training and compensation for health workers who are involved in task sharing. Discussion Taking into account the sociocultural context is fundamental for identifying local personnel who can assist in detection of mental illness and facilitate treatment and care as well as for training, supervision, and service delivery. By recognizing the systemic challenges and sociocultural nuances that may influence task-sharing mental healthcare, locally-situated interventions can be more easily planned to provide appropriate and acceptable mental healthcare in LMICs.
Quality of care provided at three NIM-ART facilities in the Greater Tzaneen municipal area: An action research project

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ABSTRACT

Background The South African Department of Health implemented the nurse-initiated management of antiretroviral treatment (NIM-ART) programme as a government policy. This policy aims to decentralise antiretroviral services to primary health care facilities. Increasing the access ART through nurse-initiation results in significant knock-on effects: increased workload and capacity constraints and logistical and infrastructural challenges. Methods An action research project used both qualitative and quantitative research methods. The study was conducted at three NIM-ART facilities in the Greater Tzaneen municipal area, Limpopo Province, South Africa, between January and June 2012. Data was collected using patient satisfaction surveys, focus groups, documentation review and facility audits. Results The patient satisfaction survey indicated a high level of satisfaction. NIM-ART nurses prescribed rationally and followed antiretroviral guidelines. Mortality rates and loss to follow up rates were lower than those at the surrounding hospitals and 91.1% of nurse-monitored patients had an undetectable viral load after a year of NIM-ART care. The quality of care provided at the three facilities was comparable to clinician-monitored care. Lack of incentives, high workload, a lack of trained NIM-ART nurses and infrastructural challenges were identified as treatment barriers. The facility audits found recurrent shortages of essential drugs at these facilities. Conclusions This action research project provided insight into the performance at the facilities and the barriers preventing the successful implementation of the programme. In addition, the quality of anti-retroviral patient care at each facility was enhanced and the mentoring practice for the practitioner researcher improved. Clinical mentors are key to addressing institutional treatment barriers and ensuring quality of patient care.
Does a trade-off exist between efficiency and quality in the delivery of integrated HIV and sexual and reproductive health services?

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ABSTRACT

Background: The re-organisation of HIV and sexual and reproductive health services (SRH) services through service integration has shown promise for improving health outcomes, and may also reduce costs of service delivery. However, improved efficiency and cost reduction may adversely impact quality of care for the patients. We therefore seek to evaluate whether a trade-off exists between efficiency and quality of care by including measures of quality in an evaluation of technical efficiency of health facilities providing integrated HIV and SRH services. Methods: Using data from 40 health facilities in Kenya (n=30) and Swaziland (n=10), two conceptual efficiency measurement models with different input-output combinations are evaluated using data envelopment analysis. One model includes technical outputs only while the other includes both technical and quality outputs to generate technical efficiency scores. Quality of care is measured using a quality index derived from structural and process measures. The structural measures of quality include availability of resources and management practices (availability of guidelines/standards and IEC materials). Process attributes include interpersonal aspects of patient engagement and technical aspects of service delivery. Results: A high degree of correlation (Pearson's r > 0.75) is found between the efficiency scores obtained using only technical outputs and a combination of both technical and quality outputs. Comparing the results of the DEA models (with and without quality measures) we find that the same five units remain relatively more efficient when the measure of quality is included in the efficiency measurement model. Conclusions: We conclude that the empirical evidence is not sufficient to identify a clear trade-off between technical efficiency and quality of care in the facilities evaluated. Nevertheless, the findings from this study imply the possibility that efficiency gains may be achieved in the integrated HIV and SRH service context without sacrificing the quality of services delivered to patients.
The significance of prevention and treatment for cervical ectopy based on Global Burden Disease

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ABSTRACT

Objective: To put forward the significance of prevention and treatment for cervical ectopy based on Global Burden Disease (GBD). Burden of Disease: Data from Institute for Health Metrics and Evaluation indicated that HIV/AIDS accounts for 3.29%, 3.67% and 1.19% of all DALYs in the world, developing and developed countries, respectively; the percentage attained 40.03% in Sub-Saharan Africa (top rank in the world). Cervical cancer account for 0.26%, 0.26% and 0.27% of all DALYs, respectively; the percentage is highest in Paraguay (account for 0.85% of all DALYs). HIV/AIDS were the leading cause in Southern Sub-Saharan Africa and Eastern Sub-Saharan Africa. Worldwide, HIV/AIDS were the sixth cause of death. Cervical cancer was the second most common cancer in women. More than 250,000 people died from cervical cancer worldwide and about 80% of them happened in the developing countries in 2005. The recent studies showed cervical ectopy was a potential risk factor for many sexually transmitted diseases. Cervical ectopy also increased the risk of HIV infection (1.2-3.9fold higher than control) and papilloma virus infection (about 1.0-fold higher than control), especially in high-risk population. Cervical ectopy accounted for 70% of gynecological clinic patients in China. The morbidity of cervical ectopy was 11.7% (2nd rank in gynecopathy) in China in 2011. Significance: In our knowledge, whether cervical ectopy should be treated or not is still controversial worldwide. Moreover, high-quality evidence of treatment for cervical ectopy is limited (e.g. guideline, health technology assessment or systematic review). According to DALYs in HIV/AIDS and cervical cancer, more studies of prevention and treatment for cervical ectopy are needed to improve the quality of life, prevent the related disease and decrease DALYs caused by them.
Access to primary health care in Timor-Leste

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ABSTRACT

Background: This qualitative research aimed to describe how people perceived community health activities and health information provided by primary health care (PHC) in Timor-Leste, where health policies and systems have been drastically changed since 1999. Methods: Multiple stakeholder interviews were conducted in November 2012 and February 2013, using three topic guides for 1) central level, 2) district or sub-district level and 3) community level. In total, information from 57 people were obtained. These comprised 12 people in related sections at the central level, 3 district health officers, 6 PHC providers at the sub-district level, 8 key informants in the community, 6 village health volunteers and 22 users. Data were analysed by the Framework Approach, applying a pre-determined framework which had been developed modifying the Andersen's and Penchansky's access models. Results: It was suggested that management systems at different levels had not caught up with newly implemented activities and programmes. Contrary to provider perceptions that users' comprehension was not yet adequate, members of the community revealed they had a range of health knowledge obtained from PHC activities. Both frontline PHC providers and users made satisfactory assessment of availability and accommodation of PHC activities, although it was not always entirely positive. Users accepted the activities in many cases; however, staff at central level sometimes raised questions regarding quality and quantity. PHC providers felt that utilisation and user satisfaction had been improving over years. Discussion/conclusion: Key health information reached the community. PHC providers perceived utilisation as an indicator of user comprehension and satisfaction, and they evaluated their own efforts. Regional data for the analyses in this presentation were from only one of four target districts. Further analyses based on the whole data will provide more information on access to PHC in Timor-Leste.
Compliance with national Tuberculosis (TB) treatment protocols: prescribers and patients perspective across Six national health insurance pilot districts in South Africa

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ABSTRACT

Background: Compliance with TB National Treatment Guidelines (NTGs) is crucial to ensure sustainable quality of care for South African patients. As important is patients education on their TB treatment as it is a key component for successful patient outcomes. Methodology: In 2012, an observational descriptive study was conducted in 36 facilities within the National Health Insurance (NHI) pilot districts from 6 provinces in South Africa, selected on the basis of the burden of TB. A structured data collection tool was used to measure compliance with the NTGs in 768 randomly selected files. Two hundred and six (206) patients were interviewed and administered a structured questionnaire to measure their knowledge about their TB treatment and the management of their condition. Results: The assessment of prescriptions compliance with NTGs showed that on average only 68% of records complied with NTGs with difference between intensive phase and continuation phase (74% and 69% respectively). For drug resistant TB treatment protocol the compliance was lower with on average 49% of the prescriptions compliant with NTGs. Lack of systematic weighting was the main cause of non-compliance. From the patients side, on average 89% of patients were able to answer all questions regarding treatment regimen. For the question related to the management of side effects only 79% of patients answered correctly. Patients knowledge of the importance of nutrition and of their own weight varied across the provinces. Conclusion: Poor compliance with NTGs for TB and the lack of systematic weighting of patients raised the need to reinforce proper record keeping and promote careful prescribing. While the majority of patients understand their treatment, they showed a limited understanding of the management of their condition. Greater effort is required in educating patients on the management of TB to improve health outcomes.
The quality of childbirth care in China: women's voices

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ABSTRACT

Background: Ensuring access to and availability of skilled birth attendance and emergency obstetric care that is effective and of good quality are key strategies to help reduce maternal and newborn mortality and morbidity. It is however important that increased coverage is matched with improved quality of care in order to influence health outcomes and to promote utilisation. In the context of improved utilisation of health care and outcomes, rapid socio-economic development and health system reform in China, it is timely to consider the quality of services. Data on quality of maternal health care as experienced by women is limited. This study explores women's expectations and experiences of the quality of childbirth care in rural China. Methods: 35 semi-structured interviews and 5 focus group discussions were conducted with 69 women who had delivered in hospitals in a rural County in Anhui Province. Data were transcribed, translated and analysed using the framework approach. Results: Hospital delivery was preferred because it was considered safe. Home delivery was uncommon and unsupported by the health system. Expectations such as having skilled providers and privacy during childbirth were met. However, most women reported lack of cleanliness, companionship during labour, pain relief, and opportunity to participate in decision making as poor aspects of care. Absence of pain relief is one reason why women may opt for a caesarean section. Discussion: Understanding quality of care in this context offers important lessons for developing maternity services in other transitional economies. These findings illustrate that to improve quality of care it is crucial to recognise the role of women as partners in their own health care, build accountability and communication between providers, women and their families, and ensure that women truly participate in decision making.
How do Malawian women rate the quality of maternal and newborn care? experiences and perceptions of women in the central and southern regions

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ABSTRACT

Background: While perceived quality of care is now widely recognized to influence health service utilization, limited research has been conducted to explore and measure perceived quality of care using quantitative tools. Our objective was to measure women's perceived quality of maternal and newborn care using a composite scale and to identify individual and service delivery factors associated with such perceptions in Malawi. Methods: We conducted a cross-sectional survey in selected health facilities from March to May 2013. Exit interviews were conducted with 821 women conveniently sampled at antenatal, delivery, and postnatal clinics using structured questionnaires. Experiences and the corresponding perceived quality of care were measured using a composite perception scale based on 27 items, clustered around three dimensions of care: interpersonal relations, conditions of the consultation and delivery rooms, and nursing care services. Statements reflecting the 27 items were read aloud and the women were asked to rate the quality of care received on a visual scale of 1 to 10 (10 being the highest score). For each dimension, an aggregate score was calculated using the un-weighted item means, representing three outcome variables. Descriptive statistics were used to display distribution of explanatory variables and Kruskal Wallis tests were used to analyse bivariate associations between the explanatory and the outcome variables. Results: A high perceived quality of care rating was observed on antenatal, delivery and postnatal care, with an overall mean score of 9 compared to a possible maximum score of 10. Being literate, use of motorized transportation, self-introduction by the health worker, and confidentiality observance were associated with a high quality rating of antenatal care. Being allowed to have a guardian and encouragement to ask questions were associated with a high quality rating of delivery care; and explanation of the purpose of the blood specimen by the health worker was associated with a high quality rating of postnatal care. Conclusions: The study highlights some of the multiple factors associated with perceived quality of care. We conclude that proper interventions or practices and policies should consider these factors when making quality improvements.
Does an Xpert MTB/RIF algorithm reduce multi-drug resistant tuberculosis diagnostic costs for patients in Cape Town, South Africa?

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ABSTRACT

Background: Whilst the newly introduced Xpert MTB/RIF (Xpert) algorithm reduced the time taken to diagnose multi-drug resistant tuberculosis (MDR-TB) compared to the existing MDRTBPlus line probe assay (LPA) algorithm, the impact on patient costs is not known. Aim: To compare costs incurred by MDR-TB patients under the existing LPA and newly introduced Xpert algorithms, from the onset of illness until treatment initiation Methods: This observational cohort study was undertaken in 10 high burden primary health clinics in Cape Town. Adult participants had been diagnosed with MDR-TB between June 2010 and December 2012. Participants completed a questionnaire detailing healthcare seeking episodes en route to MDR-TB diagnosis and treatment. Direct costs comprising medical and non-medical expenditures, indirect costs comprising opportunity costs for patient time, employment status and individual and household income were measured. Results: 153 MDR-TB patients participated, 89 in the LPA and 64 in the Xpert algorithm. Patients had a median of 20 health care visits (IQR: 10-44) to initiation of MDR-TB treatment in the LPA algorithm compared to 7 (IQR: 4-23) (p<0.001) in the Xpert algorithm. The total median cost to the patient was ZAR666 (IQR: 312-1386) in the LPA compared to ZAR373 (IQR: 138-775) in the Xpert algorithm (p=0.004). The greatest cost driver was indirect costs. From the start of their episode to being interviewed, unemployment increased from 39% to 73% in the LPA and 53% to 89% in the Xpert algorithm. Median monthly household income decreased from ZAR2533 to ZAR2118 with the LPA compared to ZAR3484 to ZAR3018 in the Xpert algorithm. Conclusion: Whilst there was a reduction in the number of visits in the Xpert algorithm, there was no significant reduction in patient costs. Household income loss is not significantly reduced in the Xpert algorithm. Although diagnosis and treatment are provided free of charge, patients incur substantial costs related to the time spent in health facilities in both algorithms. Acknowledgements This research was supported by a United States Agency for International Development (USAID) Cooperative Agreement (TREAT TB - Agreement No. GHN-A-00-08-00004-00). The contents are the responsibility of the authors and do not necessarily reflect the views of USAID.
Challenges of supervising community health service Providers:  
A context analysis of the Kenyan community health strategy

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ABSTRACT

Background: Supervision is widely presented in policies and literature as an important factor for ensuring quality of providers output. The Kenyan Community Health Strategy (CHS) is a program through which the government provides guidelines for provision and supervision of community health services. It states that Community Health Committees (CHCs) and Community Health Extension Workers (CHEWs) are designated supervisors of volunteer community health workers (CHWs) while District Health Management Teams (DHMTs) are CHEWs supervisors. We present findings of challenges faced in supervision of community health providers in the current Kenyan CHS. Methods: We collected data through a qualitative study in an urban slum and a rural district of Kenya. We purposefully selected 179 participants and conducted 10 FGDs and 40 IDIs. Digitally recorded data was transcribed and translated where applicable. Data was coded and analyzed using Nvivo10. Results: Supervision emerged as a factor motivating CHWs and CHEWs in addition to the positive health changes brought about by the CHS. Health system challenges hindering effective and consistent supervision were: lack of clear guidelines; inadequate transportation mechanisms and high workload especially for CHEWs who had dual roles as health facility and community based providers. There was emphasis on reporting tools in CHS program but providers performance measurement tools were generally lacking except in programs with NGOs involvement. It was unclear who directly supervised CHWs between the CHEWs and CHCs. CHEWs did not adequately supervise community engagement especially in relation to HIV and sexual health services provided by CHWs. Discussion/ Conclusion: Our findings underscore the need for development and operationalization of supervision guidelines and performance appraisal tools to ensure adequate and standardized supervision in CHS. The supervisors in turn need support from CHS coordinators through continuous capacity building and adequate planning for resources which should also aim at relieving CHEWs of the dual roles.
Do guidelines influence the implementation of health programs? - Uganda's experience

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ABSTRACT

Background A guideline contains processes intended to guide health service delivery. However, the presence of guidelines may not guarantee their implementation, which may be a result of weaknesses in the development process. We assessed the processes of developing health planning, services management, and clinical guidelines within the health sector in Uganda, with the goal of understanding how these processes facilitate or abate the utility of guidelines. Methods Qualitative and quantitative research methods were employed. Data collection was undertaken at the levels of the central Ministry of Health, the district, and service delivery. Qualitative methods included review of documents, observations, and key informant interviews, while quantitative aspects included counting guidelines. Quantitative data were analyzed with Microsoft Excel, and qualitative data were analyzed using deductive content thematic analysis. Results There were 137 guidelines in the health sector with programs related to MDGs having the highest number. Several guidelines duplicated content and some conflicted with each other. The level of consultation varied and some guidelines did not consider government-wide policies and circumstances at the service delivery level. The presentation was not tailored to the service delivery level. There was no framework for systematic dissemination, and target users were defined broadly in most cases. Over 60% of guidelines available at the central level were not available at the service delivery level. There was no framework for monitoring of use, evaluation, and review of guidelines. Suboptimal performance of the supervision framework that would encourage the use of guidelines, assess their utilization, and provide feedback was noted. Conclusions Guideline effectiveness is compromised by the development process. To ensure the production of high-quality guidelines, efforts must be employed at the country and regional levels. The regional level can facilitate pooling resources and expertise in knowledge generation, methodology development, guideline repositories, and capacity building. Countries should establish and enforce systems and guidance on guideline development.
Implementation of new birth records in a district of Burundi: an intervention study of health systems improvement

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ABSTRACT

Background In Burundi, the efforts of health system strengthening commenced just after a 12-year sociopolitical crisis ended. Although medical care for pregnant women and children under five has been free since 2006, its maternal mortality (500 per 100,000 live births) and child mortality (96 per 1,000 live births) remain as challenge (DHS2010). While MoH is striving to provide a continuum of care through introducing result-based finance scheme since 2010, it is inevitable to standardize health records to ensure quality of care provision as a package. Thus, JICA assisted the MoH in producing an integrated home-based record, the Mather and Child Health Handbook (MCHHB), to replace with fragmented existing records together with standardizing facility-based medical records. For exploring the feasibility of new records, this intervention study was conducted in Gitega district (population size: 244,836). Method Structured interview with pre-post tests without controlled group. Stratified random sampling based on the antenatal register at targeted health facilities. Results In prior to the introduction of new records, 522 women with 0-1 month infants were interviewed. 94% had no records on the delivery and newborn. 34% didn't know the birth weight of their infants. 80% were not explained about course of the labor by health personnel. 31% were never recommended for successive needed care such as postnatal care, child vaccination, and postpartum family planning. 75% had no records on postnatal consultation. 53% didn't have the consistency between data at the facilities and the women's reports on information about the detected problems at postnatal consultation. Discussion Needs of home-based records around birth were identified. Guidance from health personnel was still insufficient to promote continuum of care. Presentation will cover the post-test result which is to be collected in June 2014, after six months of the implementation of new records.
**Person-centeredness in diabetes care in low income countries: the effect of text messaging on patient empowerment and self-management in DR Congo, Cambodia and the Philippines**

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**ABSTRACT**

Background Health systems in LIC fail to organise adequate responses to the growing number of diabetes patients. Despite self-management and empowerment being recognised as important, the dominant care model is episodic, facility-based, doctor-oriented care. A shift in organizational models is required to improve people's self-management capacity. We studied 3 different types of diabetes care programmes: 1) Kin-réseau, DRCongo - a facility-based deconcentrated primary care model; 2) MoPoTsyo, Cambodia - an NGO-supported peer educator network programme for patient self-management support; and 3) FiLdcare, Philippines - a mix of facility-based care and community-based self-management support. In a controlled trial in each site, we randomised 240 patients to usual care, 240 patients to usual care plus daily text messages, aiming to improve competence, knowledge, feeling of control, attitude towards diabetes and health status. Analyses are done for each country separately, comparing changes over time between intervention and control group, adjusting for confounding through multivariate regression.

Methods Data were collected before and 1 year after start of intervention. Variables relate to self-management (knowledge, monitoring, medication, lifestyle), attitude towards diabetes and care (Diabetes Care Profile scales, Patient Assessment of Chronic Illness Care) and health (glycemic control, blood pressure, obesity). Analyses are done for each country separately, comparing changes over time between intervention and control group, adjusting for confounding through multivariate regression. Results At baseline, diabetes knowledge was similar for FiLDCare and Kin-réseau patients, lower for MoPoTsyo. Patients of Kin-réseau engaged least in self-monitoring. 80% of all patients followed medication prescription, 2/3 walked 20 minutes daily. Patients' assessment of chronic illness care was highest in MoPoTsyo. 43% of MoPoTsyo patients, 39% of FiLDCare, 22% of Kin-réseau reached glycemia control target. Presently, one-year results are analysed.

Discussion This study explores ways to improve self-management and empowerment in different types of diabetes care programmes and the potential added value of a mobile phone tool. Results and their differences inform us about expected effects of transferring similar technology to other programmes and contexts.
Differential pricing of essential medicines across private supply chain system in Kenya targeting the poor market segment

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ABSTRACT

Background Availability and affordability of quality essential medicines to under served populations in Kenya is a major challenge that is compounded by a complex private for-profit pharmaceutical market. The retail outlets that are at the bottom of the supply chain are always the first contact for low income people seeking health care. Severity of illness determines the choice of service delivery outlet with those in need of specialized care seeking services from mainstream private or public hospitals. Common illnesses are mostly treated at pharmacies/drug shops for urban and rural populations. Most of these retail outlets are privately owned and run as businesses; profitability is therefore a major incentive for the owners. This paper examines essential drugs pricing across the commercial private supply chain system with a pro-poor and value for money perspective to inform targeted pro-poor differential pricing interventions. Methods A review of major supply chain system actors was carried out with an emphasis on commercial private for-profit supply chain system. Five essential drugs pricing for branded and generic drugs by morbidity patterns of low income populations were used as tracer, to determine pricing and price architecture at the different levels of the supply chain. Results The results showed that pricing varied across the actors with up to a total mark-up range of about 150% - 200% cost to the end user from manufacturer/importer. Findings also showed few and non-existence of pro-poor differential pricing strategies as well as low consumer price awareness. Conclusions Considerable variability exists in pricing of essential medicines across the private for-profit market which forces poor populations to seek for medicines that are cheaper and substandard. The need for differential pricing within the private for-profit market targeting poor population market segment will increase access to affordable and quality medicines hence improve health outcomes.
Cost of pre-service education for health workers: balancing quantity and quality

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ABSTRACT

Background: The human resources for health landscape in Ethiopia faces challenges similar to other developing countries in sub-Saharan Africa, particularly regarding the quality and quantity of the health workforce. The objectives of this study were to assess the production of nursing and midwifery graduates in terms of the unit costs and infrastructure constraints, and simulate changes in unit costs arising from a proposed set of improvement interventions. Methods: Using a mix of step down and bottom up costing approaches, the USAID-funded CapacityPlus Project, the Federal Ministries of Health (FMOH) and Education (FMOE), and the US Government's Nursing Education Partnership Initiative, conducted a retrospective cost assessment of the undergraduate nursing and midwifery programs at University of Gondar College of Medicine and Health Sciences (UGCMHS) and Arbaminch College of Health Sciences (AMCHS). Financial expenditure reports, course curricula and key informant interviews were obtained from the colleges and their affiliated clinical practicum facilities. Results: The unit costs per graduated nurse and midwife were respectively US$ 1,714 and US$ 1,733 for a four-year Bachelor degree at UGCMHS, and US$ 1,051 and US$ 1,117 for a three-year Diploma at AMCHS. Both colleges faced infrastructure capacity constraints that likely affect the quality of education and need addressing before enrollment is increased. The set of priority interventions designed to strengthen faculty, support students, and upgrade infrastructure would increase the cost per graduate by 24% in Gondar and 14% in Arbaminch. Discussion: Lack of qualified staff and poor quality of care are key problems in many developing countries and the value chain of clinical quality begins with the education and training of a health worker. The results of this study can be used by the FMOH and FMOE to support planning and management of nursing and midwifery programs and to support advocacy for increased funding of these programs.
What skills are required of the health supply chain workforce? mapping competencies: documenting cadre specific competency frameworks for health supply chain personnel in Namibia

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ABSTRACT

Background: The Republic of Namibia is a country faced with a severe health workforce shortage. The Ministry of Health and Social Services note high vacancy rates, high levels of attrition, and outdated staffing norms across the health sector, including the health supply cadres. In 2011 a human resources for supply chain assessment was conducted and key partners engaged (e.g. USAID, Management Sciences for Health, Imperial Health Sciences, and The People that Deliver initiative), to address these deficiencies in a systematic way. The development of competency frameworks for the cadres involved in health supply chain, particularly for the national level, was identified as a critical enabling activity. Methods: Using the PtD Competency Compendium as a framework, a stepped approach was used involving: Desk Audit (key workplace documents were mapped against expected competency areas), Stakeholder Focus Group (validation of audit findings and contextualising of PtD Competency Compendium with key stakeholders), Workplace Interviews (mapping of cadre specific tasks and validation of audit findings with personnel), and Synthesis (bringing together the data). Results: Desk Audit: 25 documents were reviewed and mapped against the PtD Compendium with competency gaps identified warranting further discussion. Stake Holder Focus Group: 24 participants from the ministry, health supply chain personnel, academia and other supply chain partners worked together to confirm competency gaps and map health supply competency areas against cadres. Workplace Interviews: 24 interviews were conducted to map tasks and validate earlier findings. Synthesis: Distinct competency frameworks were established for pharmacists, pharmacist assistants, and clerks. Discussion/Conclusion: Strengthening quality of care for populations will require low income countries to improve their health supply chain systems. The three competency frameworks developed in this study will be used to: define cadre roles and responsibilities, develop job descriptions, review education needs, and quantify workloads for the pharmacists, pharmacist assistants and clerks engaged in medicines supply in Namibia. The methodology used in this study may be suitable in other country contexts where access to medicines is impeded through inadequate human resources.
What is the gap between patients and healthcare professions on patient engagement?

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ABSTRACT

Background Patient centeredness is a cornerstone in achieving quality health care. A patient-centered approach is therefore being used to build a therapeutic alliance between patients and the healthcare professions in care process which should be supported by a good engagement of both parties. This study aims to explore the gap of views and experiences on patient engagement in hospital setting from the perspective of patients and healthcare professions. Methods Cross-sectional questionnaire surveys were conducted separately in all healthcare professions (doctors/ nurses) and patients from public hospitals in Hong Kong. Descriptive statistics were used to analyze the percentages of variables of the study participants. Pearson's chi-square test/ Fisher’s exact test was used to assess the bivariate associations between different comments on patient engagement and the participants' demographic variables. A difference was considered to be statistically significant if the p value was < 0.05 level. Results Both healthcare professions and patients perceived 'ensuring safe care' & 'care with dignity and respect' as main components of patient engagement; however, 'sharing information' and 'share decision-making' were less widely perceived as patient engagement. 'Communication' was also identified as another important component of patient engagement by patient but healthcare professions had opposite views. Both parties alike agreed that it was important to incorporate patient engagement in care process but healthcare professions concerned with its negative impact on the service delivery. The findings also indicated that support of patient engagement was significantly negatively associated with the perceived challenges among patients and healthcare professions (P<0.05). Conclusions This study has highlighted the gap on patient engagement between patients and healthcare professions. It provides valuable information for stakeholders on how to develop action plans for enhancing the patient engagement in hospital care and towards patient-centred care.
Market segmentation and the quality of services for pediatric illnesses from informal providers in Nigeria

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ABSTRACT

Background: In developing countries, informally trained drug vendors are increasingly being viewed as health providers in efforts to expand access to basic healthcare services and improve health equity. Although Nigeria has adopted integrated community case management (ICCM) of pneumonia, malaria and diarrhea as a cornerstone strategy for reducing child mortality, little guidance exists on how this should be carried out among private sector drug vendors. This paper aims to assess the variation in quality of services from proprietary and patent medicine vendors (PPMVs) and identify which should be prioritized for ICCM implementation. Methods: In Kogi and Kwara States, a stratified, random sample of 250 PPMVs were surveyed to capture information about shop workers’ experience, training, knowledge, and practices. Additionally, we observed over 5000 customer-worker interactions that took place on a randomly selected day at each shop and interviewed the subset of customers who purchased drugs. Regression analyses are conducted to identify shop and worker characteristics associated with greater drug sales volumes in general and for pediatric illnesses, richer customer-worker consultations, and proper dispensing of recommended drugs. Results: Across all shops, 58% of observed customers purchased drugs. Descriptive statistics show that nearly half of PPMVs have formal medical training, but that the PPMV him/herself is only present half of the time when customers are present. Of customers observed to buy drugs, only 14% were buying for a sick child under age 5, and only half of the time was the sick child brought with the caregiver to the shop. Discussion of the child’s symptoms only occurred two-thirds of the time while referrals to higher-level care was rarely documented. Results of regression analyses are forthcoming. Discussion: A tiered approach to expanding PPMVs’ scope of practice for ICCM may be warranted given the large variations in PPMV qualifications, capabilities, and quality.
Factors influencing provider choice for pediatric illness in rural Nigeria

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ABSTRACT

Background: Much research on health-seeking behavior focuses on distance to health facilities and cost as determinants of provider choice. There is growing recognition that additional factors, such as perceived quality of care, play a significant role in patient decision-making. We discuss the determinants of provider choice for pediatric illness in rural Nigeria and the implications for targeting investments in local health systems.

Methods: Data are drawn from in-depth interviews with mothers of under-5 children (N=190) in 20 rural communities in three states in Nigeria. In each community, the research team mapped and interviewed local healthcare providers, including informal medicine vendors (N=120) and staff of primary health centers, PHCs (N=20).

Findings: Caregivers' decisions about where to seek care are influenced by the perceived severity of their child's illness, confidence in their own knowledge of child health, and the perceived quality of available health providers. There is widespread self-diagnosis and home-treatment for perceived non-serious illness. However, caregivers prefer to seek health services for persistent and severe illness, and for illnesses of unknown cause. In these cases, caregivers demonstrate a strong preference for attending PHCs rather than medicine vendors, even when this requires longer travel and waiting times. This preference is based on the perception that PHCs are of higher quality due to staff qualifications and the availability of diagnostic tests. Caregivers primarily visit medicine vendors in the case of self-identified minor illness.

Discussion: Caregivers' willingness to bypass more convenient providers to attend those of perceived higher quality suggests that targeted investments to improve quality at preferred facilities are more likely to lead to health impact. Investments to increase accessibility at these facilities may also encourage early care-seeking and treatment for potentially serious illness. Caregivers' reliance on self-diagnosis of their child's illness also indicates the need for health education.
An innovative approach to 'working with and not for', health system workforce improve processes of PMTCT Program : A continuous quality improvement approach

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ABSTRACT

Background: South Africa is one of countries in Africa with high prevalence of HIV, especially amongst pregnant women. The Province most affected is Kwa Zulu Natal (KZN) , with an estimated 37.4% prevalence to HIV infected women. In order for the country to reach MDG 4.5 and 6 by 2015, child deaths as well as maternal mortality need to be addressed. A University of Kwa-Zulu Natal 20 000+ in partnership with Department of Health and Institute for Healthcare Improvement (IHI) aim at health system strengthening through use of replicable Continuous Quality Improvement. An improvement project was started in rural District of Ugu with Antenatal HIV Sero - prevalence of 41.7%, the highest in the country, a District in KZN with a population of 750 000. A bold aim was to improve testing of babies at 18 months to determine post natal transmission from 30% to 60%.

Methods: A non-experimental descriptive study. Demonstration of Improvement work through engaging frontline workforce in teams, trying small tests of changes, bundle activities, using data focused approach and strengthening data usage. Results: Engaged District leadership, multidisciplinary team. Testing of babies at 18 months from below 30% to above 90 % (above aim) by six months was made. Data quality improvement noted. National Department of Health adopted this change and shared throughout country. Post natal positivity can be determined since coverage improved. Noted reduction in positivity at 18 months to be less than 5%. A laboratory of changes compiled for sharing with other Districts.

Conclusion: System gaps exist that requires a Quality improvement approach that is replicable and adaptable. Change should include people working within the system and not imposed on them ('work with and not for'), Simple innovative ideas can lead to massive process improvement.
Community mobilization and reduction of maternal and infant mortality: The case of health districts Houndé and Ziniaré, Burkina Faso

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ABSTRACT

Context Despite the implementation of numerous initiatives, maternal and infant mortality are still a major concern of health system stakeholders. Since the adoption of the strategy of primary health care as a central element in the development of the health system in Burkina Faso, it is made the use of community health workers to support the efforts of health workers to implement programs for improving health of populations. From 1992 to now, many community mobilization programs have been implemented without an evaluation of achieved results, the difficulties of implementation, perceptions and conditions of membership to these communitarian initiatives. This research aims to analyze the effects of a community mobilization program, its implementation conditions and especially the factors that influence community participation. Methods This study takes place in the health districts of Houndé and Ziniaré in Burkina Faso. Focus groups and individual interviews were conducted with women head of households, community health workers, community leaders, health workers. Results: The implementation of groups in the villages and the strong mobilization of community leaders, good perception of the work of community health workers, have improved the rate of prenatal and postnatal consultations, skilled attendance at delivery and preparation for delivery by households. Conclusion: If communitarian actions are being implemented by taking into account the sociological realities of the environment, it is quite possible that they produce better results.
Development and validation of the Tibetan primary care assessment tool

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ABSTRACT

Background. To develop a primary care assessment tool in Tibetan area and measure the primary care performance in different healthcare settings. Methods Primary Care Assessment Tool- Tibetan version (PCAT-T) was developed to measure seven domains of primary care: first contact, continuity, comprehensiveness, coordination, family centeredness, community orientation, and cultural competence. Data from a cross-sectional survey of 1386 patients visiting our sampling sites was used to conduct validity and reliability analysis of PCAT-T. Analysis of variance was used to conduct comparison of primary care performance in different healthcare settings. Results A 28-item PCAT-T was constructed which included seven multi-item scales and two single-item scales. All of multi-item scales achieved good internal consistency and item-total correlations. Scaling assumptions tests were well satisfied. The full range of possible scores was observed for all scales, except first contact and continuity. Compared with prefecture hospital (77.42) and county hospital (82.01), township health center achieved highest primary care quality total score (86.64). Conclusions PCAT-T is a valid and reliable tool to measure patients' experience of primary care in the TAR. Township health center has the best primary care performance compared with other healthcare settings, and township health center should play a key role in providing primary care in Tibet. Significance for the selected field-building dimension Develop a primary care assessment in Tibetan area and the government can use this tool to measure and monitor primary care performance.
Perception of community expectations blocks policy into practice translation of treatment guidelines in Sri Lankan rural hospitals.

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ABSTRACT

Background: There is a gap between standard hospital treatment guidelines and actual practices in rural hospitals of low and middle income countries (LMICs) like Sri Lanka. Failures in translation of policy into practice remain a significant barrier in improving patient care despite the use of different educational strategies. Reasons for this failure of translation have not systematically studied in this setting. This study aimed to explore reasons for non-adherence to the recommendations from treatment guidelines and education intervention in rural hospitals in Sri Lanka. Methodology: This was a qualitative exploration related to a completed cluster randomised controlled trial (Trail Registration Number ISRCTN73983810) conducted in 46 rural primary care hospitals in North Central Province of Sri Lanka to promote poisoning treatment guidelines using outreach education approach. Focus group discussions were conducted with doctor, nurses and non-clinical staff members in selected interventional hospitals and thematic analysis was conducted using transcribed records according to the principles of grounded theory. Results: The previous cluster RCT had quantitatively demonstrated that there was an increase in new practices following outreach education intervention but retention of old non-recommended practices. This subsequent qualitative research revealed that treatment decisions in these rural hospitals are largely shaped to meet community expectations which are, at times, not align with the recommendations from clinical guidelines or interventions. Hence, hospital doctors who wished to fit in to the local context think that community awareness programs parallel to hospital education interventions are essential when promoting updated treatment practices in rural hospitals. Conclusions: In rural Sri Lanka, community expectation is a major influence for hospital treatments. This is also seen as a barrier in promoting updated treatment practices and treatment guidelines to hospital staff. Introducing community awareness programs to provide updates of hospital treatment practices are seen as useful in shaping up community expectations.
Patients satisfaction with quality of health care & counselling: findings from a tobacco control program in India

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ABSTRACT

Background Insight into the quality of health care is important for any stakeholder including patients, professionals, and governments. A major component of quality of health care is patient satisfaction. The present study aims to explore the relationship between patient satisfaction with overall health care service and individual components of the tobacco cessation counselling algorithm in primary care settings in India.

Methods The present study was a cross-sectional survey conducted among 702 patients visiting health facilities providing primary care in 12 districts of Andhra Pradesh and Gujarat in India in 2013. Health facilities were selected by systematic random sampling and patients were recruited by simple random sampling. Information was obtained on patients' tobacco use status, reason(s) for seeking medical care, and counselling in tobacco cessation. Main outcome measures included patients' satisfaction with overall health care service. Data analysis included the use of chi-square statistics, and multi-variable logistic regression analysis. Findings Findings indicate that patients who reported they were advised to quit were far more likely to be satisfied with the overall health care service (adjusted OR9.5, 95% CI1.8-48.2) as compared to patients who did not report that they were advised to quit. Patients who were assessed for willingness to quit tobacco and assisted with the quitting methods were two times more likely to be satisfied with overall health care service as compared to patients who did not received physicians delivered assistance in tobacco cessation (adjusted OR2.1, 95% CI1.1-4.2). Conclusions Patient reports of tobacco cessation interventions delivered during primary care practice are associated with greater patient satisfaction with overall health care. Findings suggest that integrating counselling practices in tobacco cessation into routine practices of health care providers will help increase quality of health care services in primary care settings in India.
Do media have the capacity to influence policy making? findings from a multi-country cross sectional survey in sub-Saharan Africa

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ABSTRACT

Background Media plays a vital role in health policy making. In fact policy makers are more likely to read a newspaper than a scientific journal article. However, little remains known about media capacity identify, evaluate, package scientific evidence for policy. This study aimed to assess the capacity of the media to influence policy formulation and policy implementation using evidence generated from research. Method: A cross sectional multi-country survey media practitioners across 8 African countries. Results: 52 media practitioners 53%, 30% and 15% of whom were from television, radio and print media respectively were interviewed using a semi-structured questionnaire. 43% of the respondents were male while 57% were female. They had spent an average of three years doing health reporting. Although 61% perceived their capacity to evaluate the quality of the research evidence as adequate, 57% were not knowledgeable about the policy making process in their countries. Only 30% were knowledgeable about the research priorities in their countries and most of them (86%) got their evidence from meetings and workshops. 58 % rarely used research evidence in the process of compiling, editing and or disseminating news while 33% frequently engaged with researchers during this process. Conclusion: Although media are a key resource and they are motivated to engage in health reporting, there are gaps in terms of their ability to interpret, package and target evidence to reach their audiences and impact on policy making. In order to glean maximum benefit from media, their capacity to align their reporting with country priorities, identify necessary evidence and evaluate its usefulness needs to be built.
Agenda setting and policy adoption of India's national health insurance scheme: Rashtriya Swasthya Bima Yojana

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ABSTRACT

Background: India's Rashtriya Swasthya Bima Yojana (RSBY), launched in 2007 is its largest health insurance scheme, covering almost 35 million, mostly poor families. While questions on financial protection and patient satisfaction have been addressed in the literature, little has been written on how this massive scheme came on to the national policy agenda and was adopted. Methods: We use a modified version of Kingdon's approach to agenda setting and policy adoption to answer this question. In-depth semi structured interviews were conducted with those involved with RSBY design and relevant documents examined. Findings and Discussion: We argue that a confluence of problems, policies and politics best explains RSBY emergence and adoption. First, in the problem stream, the public health care delivery system was long regarded as simply not achieving its primary objective of the provision of even basic level care to the bulk of India's people. However, the national election of 2004 was seen by the victors as a mandate to address the deprivation of those in the country's unorganized sector that accounted for 93% of the workforce. Second, in the political stream, that same election empowered a set of national policy makers who favoured the expansion of social security in general, and health insurance in particular. Third, in the policy stream, technological advancements and the experience of various state-level health insurance schemes offered new policy options. A series of policy entrepreneurs, including Congress Party leaders, and officials in the Ministry of Labor got the issue on the agenda, designed the program with the help of international agencies, and implemented it in collaboration with state governments. Finally, India's high rate of GDP growth created critical fiscal space. Our analysis has important implications for understanding policy-making in India, for India's quest to achieve Universal Health Coverage (UHC), and for Kingdon's model.
Women's perceptions of Mama Kits delivered via a large-scale maternal mortality reduction program in Uganda

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ABSTRACT

Background: The use of 'in-kind' goods to incentivize the use of health services is being tested in many developing countries, in particular in the context of efforts to reduce maternal mortality. Saving Mothers, Giving Life (SMGL) is a public-private partnership that aims to reduce maternal mortality. In 3 districts in Uganda, 'Mama kits' were given to mothers when they delivered in health facilities during the first year of SMGL. They included basic supplies to assist with safe delivery, as well as items for the newborn, such as a baby blanket and diapers. Methods: We analyzed data from structured interviews with 790 women after facility delivery and evaluated data from 18 focus groups with 144 women who had recent home and facility deliveries in three SMGL focus districts in Uganda. Using multivariate logistic regression analyses, we examined the association between perceived quality of care and satisfaction ratings relative to receipt of a kit. In focus groups, participants were asked about their perceptions, decision-making process for place of delivery and reactions to the mama kits. Results: In focus groups, women reported a high level of awareness of mama kits, that they influenced their choice of delivery location, and it increased their expectations of the health system. However, inconsistent supply of the kits negatively affected their perceptions of SMGL program overall. Conclusions: Mama Kits and other non-financial incentives can both positively and negatively influence care-seeking behavior. Ensuring reliable and sustainable supply of individual interventions is important to maintain overall positive perceptions of larger scale efforts to improve maternal health.
Understanding 'scale-up' for more purposeful and effective use of systems thinking to improve nutrition

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ABSTRACT

Background: Many stakeholders have attempted to define 'scale-up' for development programs, but research has not yet determined how these definitions affect implementation. Promising interventions are often piloted, but bringing them to scale is a great challenge for health and nutrition work. Nutrition is a special case for scale-up work since it is not encompassed by the health system only, but requires an in-depth of understanding of how health, food, and other systems work together to affect nutrition. The USAID-funded SPRING Project conducted research on how implementers understand scale-up and how that understanding may shape the way nutrition work is carried out through health and other systems.

Methods: SPRING conducted key informant interviews with USAID project staff in headquarters and country offices, as well as USAID staff and other experts in the field of health and nutrition systems. Data from these interviews were analyzed to determine how understanding of 'scale-up' affects the development and implementation of nutrition programming, especially when scale-up is an explicitly named objective.

Results: Lacking an official definition, most projects rely on unofficial or personal understandings of scale-up. Preliminary results suggest that these varied understandings lead to non-uniform methods for tracking and monitoring scale up work, which only illustrate limited aspects of scale up, like coverage. In addition, this lack of common definition doesn't allow projects to incorporate the systems thinking necessary for identifying forces that will act as barriers or influences to scale-up.

Discussion/Conclusions: Scholars generally agree that scale-up encompasses more than just coverage, but also issues of equity, quality, and sustainability. A good understanding of this term that includes a broader view of scale-up and appropriate collaboration with a well-functioning health system, will strengthen nutrition project's ability to develop programs that appropriately incorporate scale, monitor those programs, and achieve the scale up they aim for.
Strengthening quality of maternal health care through social accountability mechanisms experiences from selected districts of Gujarat, India

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ABSTRACT

Strengthening quality of Maternal Health Care through Social Accountability mechanisms Experiences from selected districts of Gujarat, India Background Globally, in 2010, the global maternal mortality ratio was 210 maternal deaths per 100000 live births and India accounted for 19% of all global maternal deaths. In India, much has been done to decrease maternal deaths and bring MMR (Maternal Mortality Ratio) to 212 per 100000 live births (SRS 2011) in 2007-09. Despite the efforts, large number of pregnant women and first time mothers continue to die every hour from preventable causes. The Project and its Purpose In 2012, SAHAJ, an NGO working for the health and education of women and adolescents with a gender and a rights perspective in Vadodara, Gujarat undertook a collaborative project with two local NGOs namely ANANDI and TRIBUVANDAS FOUNDATION on Enabling Community Action for Increasing Accountability for Maternal Health in two blocks (one each in Dahod and Panchmahals district) and two in Anand district in Gujarat with the objective to enable communities to monitor access to and quality of maternal health care and to advocate with stakeholders in the health system to facilitate community monitoring of maternal health care. Strategies included: filling a tool on quality of ANC and PNC based on the NRHM standards, analyzing compiled data of the tools and producing a Report card that showed the quality of care through red (poor), yellow (average) and green (good) color coding. Majority of the quality indicators in the first report card were in the poor category. Significance for Field building dimension Following the first report card meeting, series of changes occurred. Visible improvement in quality of services is being observed during VHNDs (Village Health and Nutrition Day) which is reflected in the second report card. Panchayat members are getting involved in maternal health issues and womens groups have begun to dialogue with the health system.
Accreditation of nursing and midwifery pre-service education in East, Central and Southern Africa

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ABSTRACT

Background: Accreditation of institutions preparing health professionals for practice is essential to ensuring the quality of education they receive. The Lancet Committee report on health professional education identified accreditation as a key driver for institutional improvement globally. To date, there is no systematic assessment of health professional education accreditation in low and middle income countries. The purpose of this study is to describe the accreditation systems in place for nursing and midwifery education in east, central, and southern Africa. Methods: A survey of national nursing leadership teams from 16 countries (see map) took place during the PEPFAR-supported African Health Profession Regulatory Collaborative (ARC) meeting on July 30, 2013 in Nairobi, Kenya. Each leadership team comprised the registrar of the nursing council, the national association president, the chief nursing officer, and an academician. Teams were queried about the approaches, processes, and challenges of pre-service education accreditation in their country. Results: All 16 country teams reported an accreditation system for nursing and midwifery education. In 11 countries the nursing and midwifery council is either the sole accreditor or shares the responsibility with another (usually governmental) body; in five countries, the accreditation process did not involve the council. The process almost always involved an institutional self-assessment (14 countries) and use of external inspectors (13 countries); nine countries use an external board to review the internal and external assessments and make the accreditation decision. The funding sources for accreditation varied widely; half (eight countries) reported some or all funding from the government. Nine countries cited financial resources as a significant obstacle to carrying out accreditation activities. Discussion: This study is the first to describe the accreditation systems for nursing and midwifery education in 16 African countries. These findings are instrumental to providing tailored support to countries striving to strengthen health professional education for a new century.
Assessing the acceptability, feasibility and effectiveness of a maternal health quality-improvement strategy in public hospitals in Egypt, Lebanon, the occupied Palestinian Territories and Syria

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ABSTRACT

Background: Global efforts to reduce maternal mortality have focused on increasing trained attendance at delivery and thus, indirectly, institutional delivery - a strategy that should also reduce neonatal deaths. This approach assumes, however, that facility-based quality of care avoids harm and is life-saving. In the Middle East, access to facility-based care is not the key constraint and now most women deliver in facilities. However, our 15-year old research network entitled Choices and Challenges in Changing Childbirth has documented widespread deviation from evidence-based care for routine deliveries as well as substandard care as a determinant of maternal mortality in these countries. We are conducting an implementation research project in four public hospitals in Egypt, Lebanon, the occupied Palestinian territories and Syria. The aim of the study is to assess the acceptability, feasibility and effectiveness of clinical audit of near-miss to improve the management of maternal near-miss cases in the study hospitals. While some ad hoc review was being conducted in the study hospitals previously, audit was not institutionalized and accountability concerning quality of care is weak in the study countries. Methods: The formative stage included in-depth interviews with providers and with maternal near-miss cases or mothers of neonatal near-miss cases as well as prospective data collection in the hospitals on maternal and neonatal near-miss using a tool developed by WHO. This stage informed the intervention stage - the testing and institutionalization of clinical audit. Results and discussion: Data collection period will end May 2014. However preliminary results show favorable acceptability and effects of the audit process on the quality of care in these public hospitals. The political context in the region has had a major impact on the hospitals during this period. We would present findings from both the qualitative, formative research as well as quantitative findings on the impact of the intervention.
Variations in spending per patients on TB medicines across six provinces in South Africa: What are the programmatic implications?

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ABSTRACT

Background: As the TB programme grows, accurate information on the TB case load is essential for planning, budgeting and quantification purposes. Underestimating the number of TB patients could have far reaching programmatic implications with lower than needed resources allocated to the programme. Method: In 2012, the total expenditure for TB medicines over the financial year 2011/2012 was exported from the provincial medical supplies depot financial system from five provinces. In two provinces, data from the financial year 2009/2010 was used in the absence of reports from financial year 2011/2012. In six provinces, the expenditure came from the depot receipts of the orders placed. Only one province expenditure reflected the actual quantities issued. The expenditure per province was then proportioned by TB case load for drug sensitive TB and for multi drug resistant TB (MDR-TB). Results: The average spending per patient per year was ZAR 355 on TB medicines for drug sensitive TB, ranging from ZAR 185.34 to ZAR 914.64 across the seven provinces assessed. The provincial disparity in spending on MDR-TB medicines was even higher and ranging from ZAR 1,203 to ZAR 35,543 with an average of ZAR 9,887 per patient per year. In most provinces the spending per patient was higher than the case load would suggest. The expenditure analysis was followed by a stock management assessment at forty facilities across the seven provinces showing that overstocking of TB medicines was very rare. The depot expenditure was then assumed to be a more accurate reflection of the demand. Conclusion: The results shown that, based on the depot expenditure on TB medicines, the case load of TB and MDR-TB was in effect much higher than the eTr statistics would suggest reported. The potential under-reporting of TB cases should be thoroughly investigated to ensure the sustainability of the programme.
ABSTRACT

Background: Knowledge Translation (KT) is the process of getting research findings to policymakers for policymaking purpose. In Nigeria, because health systems are extremely weak, KT is imperative as a key factor in the promotion of evidence-informed policymaking necessary for health systems strengthening. The need to strengthen mechanisms that can systematically promote interactions between researchers and policy-makers to influence uptake of research evidence into policy, necessitated the establishment of a health policy advisory committee (HPAC) in Ebonyi State, Nigeria. The HPAC is comprised of researchers and policymakers. Objectives: To enhance capacity of the HPAC with skills/competence required for effective promotion of evidence-informed policy making and equip the HPAC to function as Knowledge Translation Platform (KTP). Methods: Capacity development workshop, meetings and mentorship programme were undertaken as follows: (i). Capacity development training workshop for the HPAC using EVIPNet SUPPORT tools; (ii). Capacity enhancement mentorship programme of the HPAC through a three-month training programme on health policy/health systems and knowledge translation in Ebonyi State University Abakaliki; (iii). Participation of selected members of the HPAC in international evidence-to-policy meetings in Addis Ababa, Congo-Brazzaville, and Nairobi. Results: Achievements/outcomes included: (a). Significant improvement in knowledge and capacity for evidence-to-policy link among the HPAC members; (b). Production of a policy brief by the HPAC to strengthen Government's Free Maternal/Child Healthcare Programme in Ebonyi State; (c). Execution of multi-stakeholder Policy dialogue by the HPAC on the policy brief produced; (d). Elimination of mutual mistrust between policymakers and researchers evidenced by cordial working relationship established; (e). Increased advocacy activity and promotion of evidence-to-policy process in the Health Ministry by the HPAC. Discussion/conclusions: The capacity of an HPAC can be developed to function as a KTP and serve as long term mechanism that allows for periodic interactions between researchers and policymakers to promote evidence-to-policy link within existing government system.
A creative way for knowledge translation: using a short comedy play in local language to disseminate healthcare evidence to 'illiterate and semi-illiterate' villagers

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ABSTRACT

Background: There is growing attention to how evidence based health knowledge can best be disseminated. A number of research and development projects have focused on the translation of best evidence aimed at clinicians, consumers and policy makers. While these projects failed to concern 'illiterate and semi-illiterate' people especially those who lived in rural areas in middle- and low-income countries. Objectives: To make a knowledge translation to 'illiterate and semi-illiterate' people in rural China. Methods: We used the knowledge gained from database of Cochrane library, UpToDate, Dynamic, Clinical Evidence and Evidence Based Guidelines. Based on the best evidence, we designed and rehearsed a series of short comedy plays in local language and performed them to villagers in Gaolan country, one of the poor counties in western China. Results: We conducted three short comedy plays about common cold, hypertension and smoking, each performance time of plays is about 15 minutes, more than 3000 villagers come from at least ten villages in Gaolan country watched our knowledge shows in local language. Preliminary results showed that villagers were very interested in our shows and can better understand the knowledge we delivered. Pilot testing led us to increase the information about what we do not know. A second round of testing is being planned. Conclusions: Pilot testing found that compared with other ways to disseminate knowledge and health education, a short comedy play in local language is a more effective and attractive approach for knowledge translation particularly to 'illiterate and semi-illiterate' people.
People-centred science: making health policy & systems research a transformative force

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ABSTRACT

Health Policy and Systems Research (HPSR) - also known as Health Systems Research - is widely regarded as a critical part of the actions needed to achieve the health MDGs, strengthen primary health care and promote universal health coverage. Yet the means through which it can influence changes in health systems toward achieving these goals are poorly understood. What is clear is that the HPSR field cannot be truly transformative if it is conducted mainly in remote isolation from the people whose behaviour and circumstances it seeks to influence. This presentation will advance and unpack the concept of ‘people-centredness’ in health policy and systems research (HPSR), drawing on experiential case studies from Sub-Saharan Africa and India. It will outline practical measures that HPS researchers can take to make their practices more people-centred, and discuss the significance of such measures for making the field more relevant for real world change. People-centred HPSR practice involves undertaking research in a manner that foregrounds human agency, attributes and values, and is acutely attentive to policy context. Change occurs at many layers of a health system, brought about by different groups of people who make up the system, including health providers, administrators, policy-planners, service users and communities. Transformative practice in HPSR can be achieved by amplifying the breadth and depth of dialogue between researchers and other system actors - recognising that these actors are all generators, sources, and users of knowledge about the system. Finally, people-centredness in HPSR requires that researchers recognize and address their own roles, position and power among the constellation of actors in the health system. The audience we address are all HPS researchers, working in government, NGO, or university settings with full-time or part-time research roles, who seek to support change in health policies and systems, so as to improve people’s lives.
Policy from the people: methodological reflections from India's national urban health Policy recommendation exercise

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ABSTRACT

In May 2013, India's National Urban Health Mission (NUHM) went into effect, placing long-awaited emphasis on improving urban health infrastructure, health service provisioning, and financing, with a focus on the poor. Acknowledging both the diversity and complexity of urban poverty across Indian cities, a Technical Resource Group (TRG) was convened by the Ministry of Health and Family Welfare to support the process. Between September 2013 and the submission of its recommendations in February 2014, the TRG convened four working groups: Reaching Vulnerable Populations, Institutional arrangements, Community Processes and Convergence, and Urban Health Financing, Governance and Phasing. Apart from review of the secondary literature, members of working groups consulted with public health experts across the country, developed, piloted and applied rapid qualitative appraisal tools, and undertook detailed situational analyses of 30 Indian cities. We spoke with officials of local body and state health department to understand the dynamics of health and related services across cities with populations ranging from 100,000 to over 10 million. In each city, focus group discussions (over 40, total) were conducted with vulnerable communities across residential/habitational, occupational and social categories to understand their vulnerability, health burdens, health-seeking and demands for reform. The recommendations of the TRG were based on extensive effort to qualitatively understand the diversity and complexity of India's urban health scenario with a specific emphasis on the conditions and aspirations of highly vulnerable groups, as well as the challenges and demands of policy implementers. Limitations notwithstanding, this process lead to nuanced, pragmatic, and locally customisable recommendations for NUHM. From the procedure of mapping of vulnerable groups to siting, construction, timing and staffing of urban health posts, from good practices in convergence for urban health to the identification of priority areas for policymaking and governance reform, we discuss the many lessons emerging from this unique exercise.
Building evidence-informed health policy capacity in Malawi through the development of evidence briefs

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ABSTRACT

Background: To support effective translation of research evidence into national evidence-based policies, Malawi has formed a knowledge translation platform (KTPMalawi) with support from Dignitas International and WHO's Evidence-Informed Health Policy Network (EVIPNet). A national steering committee has prioritized the development of two initial communities of practice (CoPs) whose mandate is to produce evidence briefs for introduction into national policy discussions. Methods: Baseline perceptions of Malawi knowledge translation (KT) stakeholders were collected using an internationally developed KT survey. Utilizing an approach developed and tested by KTPs across Africa, CoPs were formed in supply chain management and the integration of non-communicable diseases and HIV, by bringing together content specific policymakers, researchers and civil society members. These CoPs narrowed their content scopes, outlined the evidence brief problem and discussed initial policy options. Select members of each CoP were then rigorously trained in the development of evidence briefs utilizing locally identified priorities. Evidence brief authors were trained in question development, locating and evaluating research evidence from both international and local sources, and in writing for policymaker consumption. Results: Baseline survey data showed that 69% of survey respondents reported that evidence briefs were never, or rarely available to policymakers. Evidence briefs on the integration of hypertension and HIV care and on improving supply chain data management are being developed. The MoH has hired a KT Coordinator to support these efforts and is discussing how to utilize existing regulatory frameworks to strengthen evidence-informed health policy. Conclusions: The development of evidence briefs and the subsequent convening of policy dialogues is a key component of KTPMalawi and is building a critical mass of high-level KT capacity within Malawi while injecting the use of evidence into policymaking. Additional CoPs are planned and researchers are now engaging with KTPMalawi during protocol development.
Abstract

Background: Many health facility management teams rely on higher level leadership to direct or prescribe interventions for the improvement of health outcomes. These interventions, often described as best practices, implemented in a top-down manner, does not encourage local ownership, are disruptive to the local facility's work practices and not readily adaptable to the local environment [facility work culture, local factors impacting the issue, implementation capacity, resource availability and community norms amongst others.] Ownership of interventions by local management teams is critical to the successful implementation of any intervention. Ownership recognizes that those affected or directly responsible for the issues are desirous to improve their situation, that they have locally contextual knowledge of contributing factors and are aware of the appropriate intervention designs that will result in a locally acceptable solution supported by all involved. The challenge has been to provide an approach that facilitates and supports local managers take ownership, take initiatives, be innovative and remain committed to improving health outcomes in a simple yet systematic and rigorous manner. Following up on the suggestions and guidelines on how to apply the health systems building blocks framework (de Savigny & Adam, 2009), The Christian Health Association of Ghana [CHAG] has introduced a health planning approach based on the 9 health systems blocks of the 'Framework for the implementation of the Ouagadougou declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium'. The approach encourages a comprehensive analysis of health outcomes that supports the design of integrated interventions that improve the performance and synergy between multiple health system blocks. Results: Application of the approach has led to significant improvements in health facility utilization and health outcomes through interventions that address their unique multiple health system challenges.
Fostering organizational learning - researchers partnering with healthcare delivery systems in primary care transformation

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ABSTRACT

Background: In 2010, the US Agency for Healthcare Research and Quality awarded 14 grants to study primary care organizations' process and outcomes of transformation into more patient-centered care. We present our original experience with developing learning communities and knowledge translation platforms engaged in strengthening regional health systems so as to advance understanding of how research organizations can partner with health care delivery systems in health systems strengthening. Methods: Grantees collaboratively produced a literature-based framework capturing variation in: research team structure, team dynamics and the degree to which research impacted organizational learning and system change. 7 of the 14 grantees completed the survey. Their responses were analyzed for key themes. Grantee responses were arranged along the spectrum of team complexity. 4 teams were chosen for further case study analysis. Semi-structured interviews performed with the PI of each team. Responses were summarized into four case studies. Results: While research teams were typically interdisciplinary, their structures were more diverse in size, motivation, formalization, and level of partnership with the regional health services institution. Four cases representing this diversity are presented. Emerging themes include: (1) Context matters in team development and level of and methods used in dissemination efforts within versus outside the organization. (2) A tension exists between having early results to inform management, government and payers in real-time decision making and waiting for a comprehensive analysis (ready for publication). Conclusions: Considerable variation exists in how researchers interact with health care organizations and the extent to which each research team was able to foster learning internal and external to their partner healthcare organizations. One commonality among these teams was that none directly informed national policy (other than via publication). Perhaps this role is more easily played by the national government.
Open learning spirals: pedagogical innovations for peer learning to facilitate knowledge translation and capacity building towards people oriented health systems in South Asia

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ABSTRACT

Community engagement including community monitoring has emerged as a key strategy for health sector reform though the health department and its functionaries have little capacity to implement these strategies. There is a severe lack of capacity even among civil society practitioners to upscale this process, keeping the core principle of empowerment alive. Community of Practitioners on Accountability and Social Action in Health (COPASAH)- South Asia, a civil society platform has started an innovative peer learning process. The paper will describe the 'Open Learning Spiral' approach which starts with one Core Capacity Building event which includes trainees, young practitioners and resource persons. Following this Facilitated Learning Exchange (FLE) events are organised in the field area of a practitioner where more interested participants come and join the learning process. Here through a process of facilitated discussions, field visits and debriefing knowledge exchange takes place between the set of new practitioners. One or two from this group then conduct a similar FLE event in a different area adding more practitioners into the expanding community of practice. Over the last one year more than five facilitated FLE events have been held India, Nepal and Bangladesh and more than 100 facilitators from 50 community based groups have been trained. In addition to becoming part of an inclusive and expanding community of practice, these new practitioners are also sharing practice through a listserv. This grounded peer learning approach provides an experiential understanding of the overall empowering process which emphasises participation of marginalised community, as well as an understanding of the socio-political-cultural context in which the tools are applied and helps develop a people centred approach.
Human rights education for monitoring: capacity building of Community Based Organisations (CBOs) for accelerating state responsiveness to human rights issues of health care.

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ABSTRACT

The human rights perspective emphasising state’s core obligation provides an effective framework to community based organisations (CBOs) to address issues of gross denials of health rights. Being perceived as a confrontationist strategy it has not been integrated in community monitoring of health services in National Rural Health Mission in India. Some civil society organisations with human rights approach to health partnered to bring community workers from twenty five community based organisations of 18 districts together. They were imparted human rights perspectives to health and skills of community based monitoring maternal health services at the community level. A community enquiry process on maternal health services was undertaken in 112 villages across 10 districts which were selected purposively. Pictorial tools were designed on entitlements to make the data collection a simpler process. The data analysis was presented to the CBOs at a state level workshop, who in turn launched a maternal health rights campaign to disseminate the findings and to demand state response. CBOs decided to discuss the findings with the community members and in six districts a public health dialogues were held. In the state dialogue, the state level collated data, case-studies of 44 gross denials of health services including maternal death and six selected personal testimonies by the aggrieved were presented. The state officials responded by instructing the district officials to discuss and investigate matters along with the CBOs and Maternal Health Rights Campaign committee. Human right to health perspective used in combination with community monitoring tools, has the potential of empowering of CBOs and increases state responsiveness. Even in an adverse and discouraging atmosphere such as Madhya Pradesh, an eighteen months process including capacity building with human rights perspective and community monitoring skills built sufficient articulation of community workers in engaging with the state. In turn, it has proved very positive in accelerating state response to people’s health needs.
Health system guidance appraisal tool - better guidance for better health systems

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ABSTRACT

Background: Health Systems Guidelines (HSG) assists in addressing a HS challenge, but there is a dearth of high quality HSG on policies/interventions that impact HS performance/efficiency. Our goal is to develop a HSG Appraisal Tool (HSG-AT) to direct the development, reporting, and appraisal of HSG. Methodology: Stage 1: Conduct a systematic review to generate a candidate list of items/criteria for the HSG-AT. Stage 2: Evaluate the importance/priority of the candidate items through focus groups discussions. A Beta-version of the tool will emerge. Stage 3: Test the face validity/applicability of the new tool through surveys. Results: For stage 1, we identified 33 papers that met eligibility criteria. No existing appraisal tool was identified. Over one-third of the authors explicitly identified the need for a high quality tool aimed to systematically evaluate HSG and contribute to its development/reporting. Thirty candidate items/concepts were identified: problem definition, coverage, stakeholder involvement, evidence-based, operationalization, feasibility of implementation, ethical, politically sound, socio-culturally acceptable, prioritization, relevance, clarity of recommendations, transparency, flexibility, outcome indicators, resources, cost, affordability, effectiveness, cost-effectiveness, external factors, presentation, dissemination/reporting plan, updating, benefits/harm, process evaluation, impact evaluation, generalizability, sustainability, competing interests. Discussion/Conclusion: Objectively discriminating between good and poor guidelines is an arduous task since HSG quality can be regarded upon as an inherently subjective assessment that depends on a variety of health system factors and articulates with the local institutional, interests and ideologies in place. Significance: Development of high quality HSG will impacts the type of health system recommendations being formulated, their degree of implementation, dissemination, and their impact on the operation of the health system. By generating a new knowledge translation tool (HSG-AT) to appraise the quality of HSG, direct their development and optimize their implementation and reporting requirements, this project contributes to enhance the core components of the field-building dimension, strengthening quality of health care.
Health systems strengthening at the facility level: adapting a global model for local use

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ABSTRACT

Background: The WHO Health Systems Blocks Framework and the Framework for the implementation of the Ouagadougou declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium, recognize health facilities as part of the health system but do not stress on the fact that health facilities are ‘health systems’ in themselves. The concept of health systems building blocks is equally applicable at the global, national as well as the sub-national level even as far as the health facility. The Christian Health Association of Ghana [CHAG] has recognized the health facility, as a ‘health system’ in its own right, having the same system building blocks, which are expected to perform similar functions, in context, and achieve the same goals of a health system, as appropriate at that level of operation. CHAG in 2010 adopted and adapted the Ouagadougou declaration for use as a health systems performance assessment tool. Measures of performance for the WHO health systems building blocks and Ouagadougou declaration were found to be global and national in nature, yet could be applicable at the facility level. Method: Through numerous consultative processes and reference WHO and Ouagadougou frameworks, the fundamental outputs and outcomes of the 9 health system blocks was distilled, indicators appropriate to the facility level, recognizing country and organizational context, were developed along with respective sets of measures for each indicator. Results: The tool comprises 14 indicators and 29 measures, has been introduced into selected CHAG health facilities. The tool provides objective evidence on the performance of the health facilities from a health systems perspective. The OPAT is designed to be applied periodically, helping the health facility to assess its capacities in the various health system blocks as well as relate it to its performance in achieving health system outcomes.
Policy buddies - policy-maker and researcher dialogue and engagement for evidence-informed policy

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ABSTRACT

Background: Robust evidence shapes effective and efficient health services, including what services to provide and how and who to deliver them. Policymakers need to understand what research can be useful to them, and researchers need to understand policymakers' needs. We aimed to enhance policymakers' capacity to ask for and use systematic review evidence to shape policies, and researchers capacity to respond to policymakers' needs. Methods: Conducted in South Africa and Cameroon at the provincial and regional government level using five phases: (1) a situational analysis using in depth interviews to understand policy-makers' needs and factors influencing the use of research evidence in policymaking and implementation; (2) workshops to help policymakers identify research questions and draw on systematic reviews to inform questions and decisions; (3) a 'buddying' model to create links between policy-makers and researchers around specific priority policy questions identified during phases 1 and 2 (for example increasing routine immunization coverage in rural areas), captured as case-studies; (4) provision of resources to guide policy-makers and links to relevant researchers; (5) We then evaluated the model to identify lessons learnt. Results: Researchers need to understand how policy-makers operate, what their priorities are and where evidence fits into decision-making to tailor strategies to improve the use of evidence in policymaking. Pre- and post-workshop assessments demonstrated an improvement in the capacity of policymakers to formulate questions, find and understand evidence from systematic reviews and interpret it using tools such as GRADE. Results of the buddying model and evaluation, currently in progress, will be reported at the symposium. Discussion and Conclusions: Building capacity and effective engagement between researchers and health service decision makers can increase demand for evidence in decision-making and assist with prioritisation to inform policymaking. This partnership provides a knowledge translation platform would strengthen the health system through enhancing evidence-informed decision-making.
Dissemination and transferability of knowledge-based programme management skills to local capacities for leading and managing a health system in a remote resource-constrained setting

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ABSTRACT

The topic aims 1) to capture the experience of a sole rural health physician with village communities in adopting new institutional and organizational arrangements necessary for a participatory health system; and 2) to introduce the conceptual model of dissemination and transferability in the practice of people-centered health systems, organization and delivery of health services. The setting took place in a remote, geographically isolated and resource-constrained municipality in the Philippines with a population of 12,000. It was characterized by a long history and deeply embedded culture of apathy and neglect among community members in matters affecting their health and welfare. Yet, health indicators in maternal, child health and nutrition, family planning, infectious disease control and sanitation among others can dramatically improve in a span of 2 years despite the lack of human health resources when tasks are decentralized and delegated. The physician led communities through stages leading to change: an organizational and sectoral diagnosis of health challenges with stakeholders; a systems approach to problems; implementation of a clear training curriculum on management of public health programs and information system for community health workers (CHWs); policies for institutionalizing CHW’s remuneration scheme; persistent dialogue with local officials to assume roles in governance of the health system; and creation of a platform for community participation. Clear description, consensus and assignment of roles are crucial for leading and managing programs requiring multi-sectoral collaboration. Passive spread of ideas (diffusion) can happen, but pro-active and planned efforts for communities to adopt new relationships, new ways of working and new sets of behaviors and routines (dissemination) are important for mainstreaming. Knowledge of stages and complex political, socio-cultural, economic and behavioral determinants of adoption and spread (transferability) of new practices captured in a model can help field health practitioners implement participatory innovations with learning communities effectively and efficiently.
Agenda setting, policy formation and implementation of diabetes prevention in Australia 2000-2011

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ABSTRACT

Little is known about implementing national diabetes prevention programs. This paper describes the genesis, development and evaluation of a comprehensive, scaled-up diabetes prevention program. Australian Health Ministers declared diabetes a National Health Priority Area in 1996. Australia’s first National Diabetes Strategy was launched four years later. These developments, together with findings of a new national diabetes survey, evidence from international intervention trials, and a growing recognition of the potential economic and human capital impacts of diabetes, created a conducive policy environment for consideration of a new national diabetes initiative in 2006, led by first ministers of all Australian jurisdictions. This resulted in agreement to a $200 million national package to prevent type 2 diabetes, including development of a diabetes risk assessment tool. Subsequently, the Victorian Government funded a large-scale prevention program for individuals over 50 at high risk, titled Life! Taking Action on Diabetes. This program had direct lineage from the international trials, including the Finnish Diabetes Prevention Study, and built on lessons from an Australian demonstration project, the Greater Green Triangle Diabetes Prevention Program. The design of the Life! program included social marketing, risk assessment, primary care engagement, and delivery of structured group prevention courses. Between 2007-2011, over 15,000 Victorians enrolled in Life! courses run by 302 group facilitators employed by 137 provider organisations. Based on changes in waist circumference, the average reduction in the risk of progression to diabetes among participants was an estimated 39%. Program implementation has been guided by a partnership between senior policy officials, leading academics, and health professional leaders, with wide involvement of practitioners, non-government organisations and consumers. Since full-scale rollout, further evidence about good practice, replicability and sustainability has been used continuously for program improvements. New funding for the initiative was announced by the Victorian government in 2011.
How is social media being used by international health organizations?

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ABSTRACT

Learning communities are the major source of expertise and knowledge essential to large-scale implementation of effective health interventions. Who better to advise a health programme in Sao Paulo than a similar organization in Chiang Mai or Kampala? Until recently, established health intermediaries held and controlled the exclusive capability to connect people and places, and to identify, collate, compare and summarize health-related information. Despite efforts to provide globally adaptable blueprints, translation of such information into implementation knowledge can only occur through guidance and experience of others who have applied it to inform decision-making in comparable settings. Social media (SM) places these capabilities in the hands of affected communities. It is critical that the process is fully facilitated by international health organizations (IHO). We observed anecdotally that SM use by IHOs has a largely inward focus. Despite large audiences, the primary aim of much SM activity appeared to be serving institutional communications interests. The project was designed to challenge this working hypothesis, and explore to what extent current IHO use of one SM platform (Twitter) facilitates multi-stakeholder engagement and dialogue around health priorities. The primary purpose was to construct a semi-structured score-card/report and a set of related metrics to help organizations enhance their use of SM platforms. The research was conducted over 50 days in late-2013, and monitored the daily use of the Twitter accounts of: Bill & Melinda Gates Foundation; GAVI Alliance; International HIV/AIDS Alliance; International Union Against TB and Lung Disease; Malaria No More; Management Sciences for Health; Population Action International; Roll Back Malaria Partnership; Stop-TB Partnership; The Global Fund; UNAIDS; UNITAID; US Centers for Disease Control and prevention; World Health Organization. An analytical framework was developed and applied to all tweet content over the study period. A comparison of IHO score-cards and over-arching conclusions will be presented.
The challenges and opportunities of conducting ethical and trustworthy qualitative research in health systems in post-conflict and fragile contexts: Reflections from a learning community

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ABSTRACT

Focus: the ReBUILD consortium is exploring how to strengthen policy and practice related to health financing and human resource management in post conflict and fragile contexts. Ongoing research in Cambodia, Sierra Leone, Uganda and Zimbabwe deploy multiple methods, and all involve qualitative research including key-informant interviews, in-depth interviews and life histories. Purpose: We have constituted a learning community to reflect on the challenges and opportunities of conducting ethical and trustworthy qualitative research in post conflict contexts. This dialogue will be extended to the membership of the Health Systems Global Thematic Working group on Health Systems in Fragile and Conflict Affected States. Experience to date includes: (1) participants' unwillingness to speak due to anxiety and lack of trust and the fear of reliving previous traumatic experiences (2) a fear that a signature in the informed consent process may have repercussions and the importance of considering when and where verbal consent is appropriate; (3) importance of strategies for establishing rapport and supportive non-judgemental questioning are particularly critical in post-conflict contexts where there might be anxiety about discussing issues with strangers and/or researchers; (4) how far does the informed consent process stretch? - Many researchers shared experiences of participants telling a different or 'real' story once the recorder had been switched off and the ethical challenges of reconciling both 'formal and informal stories' in the analysis process. Significance: In post-conflict contexts participants may be more vulnerable and have reasons to be fearful of research encounters. Researchers need to act with integrity and be aware of the legacy we leave. Conducting qualitative research is always challenging, working in post-conflict contexts may pose additional challenges which can be supported through ongoing dialogue and experience sharing from learning communities. Target audience: people working in post-conflict and fragile contexts, and those interested in ethics and qualitative research.
Donor's involvement in health system strengthening in Mongolia: differences between thinking and doing

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ABSTRACT

Health Systems Strengthening (HSS) is a complex and essential process for better performing people-centred health systems. Yet, it is challenging to achieve sustainable and equitable health outcomes without addressing underlying health system's issues. The Mongolian Health Sector Strategic Master Plan 2006-2015 (HSSMP), developed using participatory and capacity building approach, provides a benchmark in coordinating donors support towards HSS. This research examined the extent of various actors' understanding of context-specific HSS, their power relationship and involvements in supporting HSSMP, using 2 stage face-to-face interviews with policy elites and key donors, documentary review and participant observation of the policy implementation process in Mongolia. HSSMP played an important role for increasing an awareness of systems challenges and ways of supporting the health system. Hence, both health policy makers and key health donors had a relatively strong understanding of local health systems challenges and the importance of contributing towards HSS. Despite their common understanding of HSS, their actual contribution to HSS greatly varies, reflecting their differing approaches towards HSS. Asian Development Bank approaches have been most supportive of HSS and are largely aligned with HSSMP priorities. Bilateral and multilateral agencies still prefer to use vertical programme approaches, except GIZ (German Society for International Cooperation) which employs a capacity building approach to address health systems challenges. Donor's existing Monitoring and Evaluation processes prioritize output indicators; this shifts the focus away from process indicators that would demonstrate support of HSS. Changes in both government and donors are necessary to overcome the constraints around supporting HSS. The government needs to maintain adequate and consistent leadership in coordinating donor's support, and donors should become proactive in changing their monitoring and reporting procedures to demonstrate support towards HSS. The development of a core set of commonly agreed indicators to measure HSS interventions is needed.
Making health coverage programs more responsive to informal workers and their families: Lessons from a learning community of researchers and policymakers

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ABSTRACT

Many countries are facing the challenge of expanding the breadth of population coverage to achieve people-centered health objectives. Extending health coverage to informal workers and their families is particularly difficult because of challenges in defining, targeting, and enrolling this population, and in financing coverage efficiently and equitably. Through the Joint Learning Network for Universal Health Coverage (JLN), a learning community has convened to explore issues related to extending coverage to the informal sector, with a focus on sharing lessons, successes, and innovations from countries that have made strides in covering this population or are taking concrete steps to do so. The JLN community has engaged in frank dialog focused on highlighting country challenges, successes, and innovations related to: political and policy environment and public opinion; financing mechanisms; identification, targeting, enrollment, and premium collection; information and socialization; insurance organization responsiveness; and people-centered results. Lessons from this community of researchers and policymakers draw on findings from informal worker surveys (Indonesia), well-controlled trials (Vietnam, Philippines), administrative stick and carrot approaches (China), political economy analysis (South Korea), and other pilots and policy innovations. The joint learning platform has contributed to the knowledge base of the broader JLN community through documentation of findings communicated in the peer exchange, in addition to development of country case studies and a paper (in press) synthesizing the global evidence. The learning community, through practitioner-to-practitioner collaboration, has co-produced pragmatic technical knowledge around extending health coverage to informal workers and their families, delving into the interplay among (1) research and evidence, (2) advice from peer policymakers and implementers, and (3) political considerations in extending coverage. Many lessons gleaned from the JLN learning community around the informal sector are relevant to other countries across the income and geography spectrum that face the challenge of expanding coverage to this difficult-to-reach population to achieve people-centered health objectives.
NICE international: building local capacity and developing global public goods for improving health priority setting

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ABSTRACT

Purpose: To share NICE International’s original experience of knowledge translation platforms including within-country initiatives and development of global public goods that strengthen health systems through improved priority setting. Background: The British National Health Service (NHS) is well-known globally for its commitment to Universal Health Coverage (UHC) regardless of patient’s ability to pay, and for its relatively low cost of health service delivery and comparable health outcomes. The National Institute for Health and Care Excellence (NICE) plays a key role in advising the NHS on priority setting to improve quality of care for patients. As many countries endeavour to achieve UHC, the experiences from NICE become increasingly important. NICE International (NI) is a team within NICE that aims to contribute to better health globally through more effective and equitable use of resources. NI has conducted a range of international activities to support local teams develop local solutions by advising on the use of evidence and social values in making clinical and policy decisions, utilising the skills, knowledge and technical capacity of NICE and its stakeholders. Focus: Examples of individual projects conducted by NI in conjunction with local policy makers, health workers and researchers in low and middle-income countries include the development of quality standards for stroke care in Vietnam and improving maternal care processes in Kerala, India. NI's knowledge translation platforms extend beyond individual projects and include global public goods such as development of standardised methodology for conduct of Bill and Melinda Gates Foundation-funded economic evaluations under the platform of the International Decision Support Initiative. Significance: Robust priority setting mechanisms are an absolute requirement of health systems that endeavour to achieve universality. The original experience of NI's work is highly significant to strengthening health systems through examples of local projects and global public good development that improve priority setting processes.
Political economy of decentralization of health system in El Salvador

Bossert, Thomas

ABSTRACT
Designing an effective and responsive decentralization policy is a challenging technical and political process. A research project involving collaborative diagnosis of the health system and municipal governments in El Salvador was implemented as a step in developing a persuasive argument for a set of feasible policy options for the incoming new administration. With a local consulting firm and a sub-secretariat of the Presidency of the Government of El Salvador, the author led a mixed methods research project involving an exhaustive review of documents, reports and publications with field visits and focus groups in three territorial groups of pilot municipalities. The study was to establish the degree of decentralization (using the author's decision space concepts), characteristics of local capacities and mechanisms of accountability both to the local community and to responsible higher authorities. This diagnosis also included reviews of different international experiences in health system decentralization with a focus on Chile, Colombia, Brazil, and Mexico in the Latin American region as well as some other case examples from Pakistan, India, South Africa. These examples were then used to assess how alternative proposed reform policies could take into account realistic context characteristics in El Salvador. These proposals anticipated options for expanding decision space in territorial offices of the Ministry of Health (deconcentration) and municipalities (devolution) as well as accounting for existing and potential capacities and mechanisms for accountability. This research was then used as part of a process of consensus building among key stakeholders to develop a proposal that might be politically feasible. This process itself is then analyzed in detail to identify the different positions of the key stakeholders (in focus groups in workshops). This analysis was used to develop a political strategy to gain more support for the feasible options in the future administration.
Examining implementation of tobacco control policy at the district level: A case study from a high burden state in India

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ABSTRACT

Introduction: While extensive scientific evidence exists on the tobacco epidemic, a lack of understanding of both policies and their appropriate way of implementation continues to hinder effective tobacco control in developing countries such as India. We conducted a stakeholder's analysis to understand current implementation practices and the challenges faced in implementing tobacco control policies at district level.

Methods: We chose a qualitative study design to do this stakeholder analysis. A total of 42 in-depth interviews were undertaken with seven district officials from a southern state (Andhra Pradesh) in 2011. A semi-structured discussion guide with priori themes was developed for a systematic process in the interviews. The codes that were inducted from the data were used to label chunks of data by using Atlas Ti software for data analysis. Review of the coded data and reflection on the initial conceptualization led to refinement of the concepts. A Case Analysis approach analyzed the data in 2 stages: cases were based on their positive, negative or no/neutral responses for each interview and grouped accordingly. The transcripts were then reviewed as multiple comparative cases.

Results and Discussion: Most stakeholders were unfamiliar with the existing comprehensive tobacco control policy. Respondents have ambiguous opinion regarding integrating of tobacco control programme into existing health and development programmes. Tobacco control was seen as low priority issue for most of the stakeholders. Stakeholders perceive lack of inter-sectoral coordination & resources, low prioritization of tobacco control in health and development programmes and lack of monitoring and evaluation of implementation of smoke-free laws as factors affecting successful implementation of tobacco control policies.

Conclusion: This study highlights the need for a systematic action plan for effective implementation of tobacco control policy at the district level. Empowering district level managers and resolving operational barriers will help mainstream tobacco control programmes.
Changing the healthcare-landscape in Groningen, the Netherlands: Accounting for multiple voices

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ABSTRACT

Background: As many other European countries, the Netherlands faces an increasing demand for care for older adults and chronically ill due to an ageing population. Particularly in rural areas, this leads to shortages in first-line care, exacerbated by budget cuts. The Dutch healthcare policy is making efforts to move away from the traditional 'social care state' to a policy featured by increasing participation and social accountability. Community councils are now responsible for transforming the healthcare in their communities. This paper describes a unique participatory action approach (PAA) used in Northeast Groningen province, where community councils practice participatory decision making by jointly reconstructing a new healthcare landscape that incorporates the voices of health-insurance provider Menzis, healthcare providers, 'Zorgbelang' (umbrella organization for patient interest groups), University of Groningen, and local community.

Method: The PAA was chosen to encourage greater responsiveness to a future healthcare landscape. Introductory meetings in three communities were organized for chronically ill and informal caretakers, followed by five focus group discussions (FGDs). We captured current experiences and expectations regarding policy changes and roles of formal and informal caretakers. Verbatim transcripts were coded, analyzed and validated. Results will be presented and discussed in a regional meeting in which all stakeholders participate.

Some preliminary findings: We identified a large diversity in informal care activities and associated concerns. Across communities, social networks are crucial for coping with the high physical and mental burden that informal caretakers experience. Caretakers are concerned about the increasing physical and mental workload and the lack of information in the future. Experienced social-environmental (housing, transport) and bureaucratic challenges to obtain formal support affect the wellbeing of both chronically ill and caretakers, often outweighing concerns of changing healthcare provision.

Conclusion: These findings will help determining the outline of a more people-centered integral healthcare system of formal and informal sectors.
Can targeted leadership and management training for health managers result in better health outcomes in urban informal settlements? The Kenyan experience

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ABSTRACT

Background: The rapid urbanization in Kenya has resulted in a population of over 58% of urban residents living in slum-like conditions. In the wake of this rapid urban growth, the formal health care delivery system has not kept pace with the growing needs of the population. Research done in the slums of Nairobi has shown that less than 1% of health facilities serving these settlements were public. Although private providers cater for a significant proportion of slum residents, health care workers in this sector rarely benefit from in-service training to update their skills to offer essential services such as emergency and basic obstetric care, family planning and management of common childhood illnesses. More than a decade of research by in the slums of Nairobi, Kenya shows that these areas exhibit poor child, neonatal and maternal health indicators including high levels of maternal mortality (709/100,000), high neonatal, infant and under-five mortality. The African Population and Health Research Center rolled out a 3 year project, 'Partnerships for Maternal, Neonatal and Child Health (PAMANECH)' in Viwandani and Korogocho informal settlements of Nairobi, Kenya with the aim of strengthening public-private partnerships for the improvement of health care services and outcomes for mothers, neonates and young children through various strategies: service delivery, leadership and governance, health work force and the health information system Objectives: To determine the effect of strengthened public-private partnerships on the quality, accessibility, and affordability of maternal and child health services Methodology: This is an intervention study with pre and post-intervention phases to assess the impact on the MNCH services and population health outcomes. Data were collected at baseline and is continuously being collected, from multiple sources including health facility and community data, examining trends and trying to find explanations for the findings. Results Data analysis of preliminary findings is currently on-going Policy implications The findings will show effectiveness, if any, of the intervention and possibly provide a model of public-private engagement for adoption by the local and central governments, for under-served populations like slums, in Kenya and other sub-Saharan African countries.
The latent stakeholder in health care reform: understanding private employers' perception and position in Hong Kong

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ABSTRACT

BACKGROUND: As governments around the world take up health care reforms, identification of and communication with key stakeholders has become increasingly critical for its success. Sometimes, a stakeholder who is latent in the early discussion of policy debate can take subsequent action and become crucial to the reform. Through an analysis of private employers' perception and position as the current healthcare financing reform unfolds in Hong Kong, this study aims to demonstrate the importance of such latent stakeholders, and provide lessons for other reformers to engage the private sector more effectively.

METHODS: A questionnaire survey from 439 private employers and three focus group discussions among 19 company representatives were conducted to gauge employers' knowledge and impression of the general reform direction as well as attitude towards specific policy changes. Subgroup analyses and regressions were performed to identify factors affecting employers' position. RESULTS: We found relative low awareness and interest as well as somewhat dispersed impression of the reform across a wide variety of company sizes and industries. Employers showed willingness to take shared responsibility for population health, with the right support and incentives. However, possible unintended consequences emerged during discussion (e.g. crowd-out of current employee benefit offer), underlining the importance of including employers in the reform discussion as early as possible. CONCLUSIONS: The government so far has failed to recognize employers' critical role in financing health care, which led to this key stakeholder being largely overlooked in the policy debate. Our findings imply that actions taken by employers could potentially make or break the reform. The agnostic and unengaged employers could be turned into a much more active and salient stakeholder in the health care reform process, but such transformation requires much stronger recognition and targeted outreach efforts. Financial incentive, particularly, broad-base tax concession, is a strong lever for persuasion.
Integrating community evidence in addressing barriers to primary care level sexual and reproductive health services in Uganda

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ABSTRACT

Many health workers in Ugandan primary care services suffer poor work environments, low pay and few motivational incentives for outreach to or interaction with communities. Communities in turn may lack capacities to negotiate or communicate with service providers, leading to misunderstandings and even anger. For low income women and adolescent females, these shortfalls can prolong delays in access to and use of services for sexual and reproductive health (SRH). This paper presents work by HEPS Uganda with four Ugandan CSOs - AGHA, NAFOPHANU, CEHURD and UNHCO - and with technical support from TARSC to develop and use participatory reflection and action methods as part of a programme of health literacy at community level in six urban and rural districts in Central, East and Western Uganda. We used the methods to identify and address barriers to uptake of SRH services, and to improving communication between health workers and communities. The paper reports background evidence from a desk review on delays in uptake of SRH services and compares these findings with barriers identified using participatory methodologies with grass root communities, primary care level health workers and policy makers in the pilot districts. We compare also the proposals for improving uptake of SRH services from communities against the profile of services and actions gathered in the desk review. We present the actions taken in these pilot areas and their impact on uptake of SRH commodities and services, and on engagement of health workers with communities, using progress markers identified by those involved to assess change. The CSOs formed a coordinating group to plan, review and support roll out of the activities, mentor the work and share learning and the paper will present the lessons learned from this pilot process that may inform work in similar settings on overcoming barriers to using SRH services.
Moving from innovation to institutional practice: embedding participatory action research and health literacy in primary care services in Zambia

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ABSTRACT

Participatory Reflection and Action (PRA) processes involving health workers and community representatives have been found to enhance team working, participatory decision-making and use of local ideas for solving health problems collectively. This paper presents how these processes have been used to build a link between research, knowledge and action in Zambia from 2005 to current, in growing steps of learning and action that have transformed primary health care practice in Lusaka, and are now being scaled up to national level. The steps and learning in the process are reviewed, starting with involvement of communities in budget and planning in selected sites Lusaka, to identify and take action on risk factors leading to public health problems such as cholera. Improvements found in both qualitative review of service performance by health workers and communities and reduced levels of environment-related diseases built commitment in to the process from communities, managers and frontline workers and built capacities for a wider roll out of the process to identify and solve other health problems. The next step integrated the process into institutional practice in Lusaka in 2009, through a health literacy programme that would apply PRA methods to a wider range of health and health system issues, integrating the work as part of the functioning of frontline services, and building tools for regular monitoring, review and support. The PRA capacities in existing clinic catchment areas were used to mentor and build capacities in neighbouring areas. In 2011, the gains in public health made from the work triggered support from Ministry of Health for a national scale up of health literacy from Lusaka to other provinces. This step is now in process. The authors review the learning and challenges in taking an intensive, participatory process for building people centred health systems from local to national level.
High striker: An examination of public hospital reform in China

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ABSTRACT

Background: Public hospital reform is an important yet vexing area of China’s national health reform. However, little information is available about the decision-making processes of hospital leaders. We sought to characterize Chinese hospitals’ experience with healthcare reform, competition, and accreditation. Methods: We conducted in-depth interviews with hospital presidents and vice presidents (n=52) who represent a diverse range of geographic regions in 2013. Data were organized using HyperResearch software and analyzed using the constant comparative method of qualitative data analysis. Results: Five themes characterized hospitals’ experience: commitment to universal health coverage despite economic contraction; health insurance coverage expansion as a leading market driver; aggressive increase in hospital size; hospital expansion calls for improvements to operations and management; and changing composition of the hospital population as a catalyst for revamp of accreditation criteria. Conclusions: These themes characterized promising and innovative strategic planning in the midst of turbulent regulatory and market environments. This study informs the refinement of public hospital reform goals by distilling the complex and diverse experiences with hospital change.
Social accountability and health system performance in Zambia

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ABSTRACT

Background: Social accountability is increasingly invoked by global health policy makers and programmers as a way to improve health care responsiveness and quality. However, little empirical research exists to explain how, and in what contexts, mechanisms of social accountability work. We conducted a qualitative evaluation of a World Vision International's (WVI) social accountability model - Citizen Voice and Action (CVA) - on health systems in three rural districts in Zambia. Methods: In-depth interviews (IDIs) were conducted with eight WVI staff, seven District officials, and four health facility personnel. Focus group discussions (FGDs) were conducted with 14, 17, and 6 community members respectively from the three districts. All interviews were recorded, transcribed, and coded, using inductive and deductive methods. Results: CVA involves three stages: 1) citizen mobilization and civic education; 2) participatory performance monitoring and the development of corresponding action plans; and 3) improving services and influencing policy. CVA substantially improved citizen's knowledge of health policies and their competence and willingness to advocate for these entitlements. The acquisition of new communication skills by CVA-trained advocates, their ability to ‘dialogue’ non-confrontationally, and enhanced respect between citizens, service-providers and administrators, were key factors underpinning successful interface meetings in all districts. Action plans led to concrete improvements in health services (e.g. strengthened availability of supplies and human resources) realized, in part, through better awareness and utilization of existing public funding and consultation mechanisms. Acceptability of CVA was enhanced by WVI's long-term presence and reputation in all the communities concerned. Conclusion: CVA appeared to change the mindsets of frontline providers and community members in a several key ways demonstrating clear potential of this model. Future research in settings beyond Zambia will help to flesh out the mechanisms at play in different contexts, facilitating the distillation of key principles for successful CVA.
Unpacking the governance dimensions of national community health worker programmes: case studies of the provincial implementation of primary health care outreach teams in South Africa

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ABSTRACT

Background: There is a global swing back towards community health worker (CHW) programmes in health systems. While there is considerable international literature on the roles and efficacy of CHWs, and to some extent on immediate support systems (e.g. supervision and incentives) required, there is little on the governance & leadership tasks of programmes at scale. South Africa is currently reorienting a loosely structured and highly diverse NGO-based community care system that has evolved around HIV/TB, into a formalized, comprehensive and integrated CHW programme. CHWs are organized into 'PHC Outreach Teams', supported by nurses and linked to PHC facilities. Methods: We report on case studies of implementation of the national PHC Outreach Team strategy in three South African provinces (Western Cape, North West and Gauteng), highlighting key elements of the governance & leadership role in managing the shift from a limited purpose care infrastructure to an integrated and comprehensive CHW programme. The case studies were conducted in 2012/13 and involved multi-level interviews with stakeholders from senior to front-line, document reviews and analysis of secondary data. Findings: The key governance & leadership roles that the cross case analysis revealed were: 1) negotiating a fit between national mandates and provincial histories and strategies of community based services 2) defining new organisational and accountability relationships between CHWs, local health services and NGOs 3) developing new human resource, financing and information systems to enable integration, and 4) building new visions and managing change processes. Specific contexts shape governance & leadership roles e.g. capacity for NGO contracting in the Western Cape, a strong district health system in North West, and family physician led local innovation in Gauteng. Conclusion & Significance for the field: Through this analysis we hope to contribute to greater understanding and definition of the governance & leadership role in national CHW programmes.
Understanding political priority development for public health issues in Turkey

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ABSTRACT

Background: Turkey has been widely regarded as one of the global leaders in tackling tobacco use. Unlike tobacco control, however, road safety has historically not received political priority in the country. Experts have explained that even when much is known about a disease or injury as well as its interventions, political actors may not prioritize it. Slow progress in reaching international goals could, therefore, also be explained by the lack of political will. Unfortunately, however, there is a dearth of research in this area to help us understand how political priority is developed in countries like Turkey. Objective: The primary objective of this study is to understand the process and determinants of how tobacco control became a political priority in Turkey and why road safety has not using a framework adapted from John Kingdon’s Multiple Streams Theory. Method: Using purposive sampling, 42 interviews were conducted with 39 key informants. These key informants, defined as individuals who have played a significant role in or have extensive knowledge of tobacco control and/or road safety in Turkey, represented universities, donor agencies as well as governmental, non-governmental, and international organizations. Results: Findings revealed that among the factors that contributed to the development of political priority for tobacco control in Turkey were the presence of facilitating global conditions, personally interested political leaders, knowledgeable and well-connected policy entrepreneurs, strong civil society, a conductive national mood, as well as international funder and technical advisors. As one respondent aptly described “every piece of the puzzle was in the right place at the right time.” Road safety, on the other hand lacked personally interested political leaders, policy entrepreneurs, strong civil society, and a cohesive policy community. Conclusion: Results from the study can be used to assist those striving to promote public health issues in Turkey and/or other similar contexts.
Lessons learned from implementing the new governance structure of regional healthcare in Thailand: a complexity science perspective

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ABSTRACT

Objective: Despite a considerable success in implementing the universal health coverage policy in the past decade, Thailand is currently developing a more people-centered and equitable health system. To improve equity and efficiency of services delivery, a new structure of healthcare governance at regional level has been proposed and implemented nationwide since 2013. This empirical study aims to evaluate how this new governance structure really performs, particularly how its emerging leadership can influence organizing services delivery in more equitable and efficient fashions. Methods: This observational study employed qualitative data analysis. Qualitative contents were collected from focus-group interviews of state hospital administrators, and policymakers in Ministry of Public Health and National Health Security Office. Content analysis was used to synthesize emerging themes in decision-making within the new regional healthcare systems, especially how health resources are allocated towards equitable and efficient systems. Results: It is expected that content analysis will reveal how the new governance structure is implemented differently in 13 regions nationwide. Emerging themes related to coherence of decision-making, level of stakeholder participation, transparency of supervision and regulation, and consistency and stability of governance structure will be synthesized. Crucial processes in steering each regional healthcare system towards equitable and efficient healthcare will be identified. Discussions: The newly established governance structure of regional healthcare systems is a promising mechanism to accelerate a development of equitable and efficient healthcare system. Looking through the complexity science perspective, we can expect that different cultures and values between policymakers, managers, and practitioners at multiple levels influence uncertainty in all implementation processes. Strategies that potentially can facilitate good governance and effective leadership in this complex adaptive health system are proposed.
The oral health policy in Nigeria: the role of context and actors in its development and approval

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ABSTRACT

Introduction The high level of oral disease burden in Nigeria, inadequate human resources and insufficient, poorly coordinated services galvanized the development of an oral health policy (OHP) after many years of neglect and previous failed attempts. This presentation explores the role of context and actors and possible reasons why this succeeded where others failed. Methods The study was undertaken in Nigeria, a coastal West African country with a population of 170 million. The OHP was one of three policies analysed in a project. Information was gathered through document reviews and in-depth interviews with policymakers, academia, researchers, civil society and development partners. Data were analysed using a framework approach supported with NVivo software. Findings The context was that of a long yearning for an OHP. There was an on-going conversation about a National Strategic Health Plan and there was no OHP to be incorporated into the plan. This appeared to have influenced the buy-in of stakeholders to see through the development and approval of the policy. The document went through all stages of policy approval, up to the Federal Executive council which is the highest body responsible for approving policies. Actors played different roles in the process but worked synergistically to produce the OHP document due to the common interest in producing the first approved OHP in the country. Conclusion There is no single factor that can catalyse policy development alone. Availability of evidence is necessary but not sufficient. The context in which actors develop policy can facilitate and/or constrain the actors' roles and interests. These wider social and political contexts must be taken into consideration at every stage of policy development in order to produce policies that will strengthen the health system. This is especially crucial in low and middle income countries.
Conceptualising people-centred health systems: The experience of 'real' health systems in an urban informal settlement in northern Nigeria

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ABSTRACT

Background Interventions to strengthen health systems tend to be developed using a functionalist perspective, which conceptualises systems as formal, state-led health institutions comprised of a series of interdependent 'building blocks' of finance, information, service delivery, governance or technology. In the vast majority of cases, the initiatives place the state at the centre of service delivery. In fragile states where the government is largely absent, local people are challenged to create informal systems for health which often go unacknowledged. The concept and practice of people-centred health systems at a micro-level is vital in order to advance the field of health systems and policy research.

Methods We developed conceptualisations of people-centred health systems using a qualitative case study approach. Interviews (34) and focus groups (3) were conducted with people experiencing a range of health problems in Tudun Jukun, an urban informal settlement in northern Nigeria. We used case analysis techniques to describe how problems evolved and were addressed, taking the perspective of health systems as social arrangements.

Results Health systems interventions do not acknowledge that 'real' health systems are informal, complex, pluralistic and social. The state is not present in people's lives and more often is experienced as just one of many private health systems actors whose interest may differ or even conflict with residents'. Values, community resources and networks (including household dynamics) are crucial in terms of making decisions to provide informal care versus seeking access to wider resources and/or institutions. Discussion/conclusions Local services must engage with people's beliefs to really understand what they value (or not) and open up their processes so people can feel services belong to them and they matter. This also raises difficult questions about the effectiveness of international development assistance for health systems strengthening when the state has little role in people's lives.
Posting & transfer of government health workers: implementation experiences and perceptions on the functionality of the health system

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ABSTRACT

Background: The need to augment health infrastructure and address workforce shortages dominate global debates on health systems strengthening - yet, the equally important dimension of managing the current workforce has not drawn proportionate attention. Posting and transfer (PT), encompassing placement, promotions, demotions and transfers to ensure an optimal mix of health workers for the delivery of quality services, is one such crucial element of health workforce management. In this paper we explore the processes of implementation of policies for PT of health workers at primary care level in Tamil Nadu state, India. Methods: Based on 'bottom up' frameworks of policy analysis, processes of implementation of P&T policies were investigated from the perspectives of participant actors. In depth qualitative methods used included 13 interviews with health providers and officials at different levels of the system. Thematic data analysis was undertaken using a combination of structural and reflective analytical frames. The study was conducted in two Primary Health Centres in one district of Tamil Nadu. Results: PT policies were implemented through a consultation process which is designed to provide options for placement, minimise subjective decisions of administrators and enhance transparency, and was generally seen by health workers & administrators in a positive light. Administrators frequently used PT as a coping mechanism to deal with chronic workforce shortages. Among health workers PT is widely regarded as a means to move to more (socially or professionally) desirable locations. Discussion: The PT policy of the state assigns multiple objectives including equitable workforce distribution and transparency of health services. The role of PT in influencing services needs and utilisation of services by communities, and in career trajectories and professional growth of the health workers remain neglected goals. These focuses of PT policy need to be balanced, to promote greater responsiveness to both- service users and service providers.
Building capacity in a ministry of health through distributed adaptive leadership: a case study

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ABSTRACT

Purpose: The USAID-funded, IntraHealth International-led Palestinian Health Capacity Project (PHCP) is working with the Ministry of Health (MOH), Palestinian Territory, to strengthen governance capacity. 'Governance capacity' is an acknowledged element of well-functioning health systems, but it was difficult to find clear definitions to guide an assessment of MOH functional strength in that area. Previous work on strengthening governance capacity in settings similar to the Palestinian Territory was also lacking. PHCP, therefore, designed a tool (Organizational Capacity Learning and Assessment Tool or OCLAT) that assesses governance capacity in the dimensions of leadership, management, establishing policies, and using a regulatory framework. Participants use a closely defined scale to rate their responses so that the tool can be used to plan interventions and track improvements in each dimension. Focus: Two sets of results from use of the OCLAT tool will be shared, focusing on the primary assessment and measurement of subsequent organizational learning within the MOH. A group of 21 midlevel managers selected by the Deputy Minister of Health is playing a critical role in leading change processes within the MOH, being captured through case study-based research. The research shows the effects of distributed adaptive leadership defined as the work of all individuals who contribute to leadership practice within a complex system, whether or not they are formally designated as leaders in strengthening MOH governance capacity. Significance: The OCLAT tool could be adapted for other MOH settings, as could the method of using distributed adaptive leadership. This presentation will showcase OCLAT and case study results of changes in organizational capacity and the role of change leaders in the Palestinian Territory MOH, both of which could have wider applicability. Audience: The OCLAT tool has relevance for policymakers, researchers, programs building health systems capacity, and those involved in post-conflict health systems development.
Community, provider and policymaker perceptions of community health policy in Kenya: implications for policy change.

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ABSTRACT

Background: Global interest and investment in close-to-community health services is increasing and Kenya are presently revising their Community Health Strategy (CHS) alongside political devolution, which will result in re-visioning of responsibility for local services at County level. This paper aims to explore drivers of policy change from key informant perspectives and to study perceptions of current community health services from community and district level, highlighting implications to inform unfolding discussions for managing policy change. Methods: We conducted forty in-depth interviews and ten focus group discussions with a range of participants to capture plural perspectives, including those who will influence or be influenced by CHS policy change in Kenya (policy makers, district health management teams, facility managers, Community Health Extension Worker (CHEW), Community Health Workers (CHW) and community members) in two purposively selected counties: Nairobi and Kitui. Data was digitally recorded, transcribed, translated, and coded prior to framework analysis. Results: There is widespread community appreciation for the existing strategy. High attrition, lack of accountability for voluntary CHWs and lack of funds to pay CHW salaries, combined with high CHEW workload are seen as main drivers for strategy change. Areas for improvement identified include: lack of clear supervisory structure including provision of adequate travel resources, current uneven coverage of community health services, limited community knowledge about the strategy revision and demand for home based HIV testing and counselling (HBTC). Conclusion: Recommendations are provided to raise awareness of strategy revision, strengthen supervisory systems, monitor and address equity concerns including coverage, pilot HBTC and build the engagement of communities with the revised strategy to increase social accountability. These recommendations seek to inform the process of policy management to contribute towards a more people-centred health system for improved equity, effectiveness and success of policy change through the roll-out of the revised strategy.
Barriers to acceptance and utilisation of skilled birth attendants in 16 villages in South West Sumba and Cianjur districts, Indonesia

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ABSTRACT

Background: Indonesia has developed a strategy to ensure skilled birth attendance by the Village Midwifery programme implemented in 1987. Yet the utilisation of skilled birth attendants in SW Sumba and Cianjur is moderate (46% and 60% in each province) with deliveries by traditional birth attendants (TBA) persisting. We explored the reasons for TBA utilisation. Methods: We conducted a total of 110 semi-structured interviews and 7 FGDs amongst informants in 8 villages in South West Sumba, a predominantly Christian rural Island and 8 villages in Cianjur, a predominantly Muslim, peri-urban district in East Java. The informants included village midwives/nurses, ‘Posyandu kaders’ (village health volunteers), TBAs, mothers and husbands, village heads and district health officials. Findings: TBAs are preferred because of convenience, close proximity and ease of contact and their adherence to traditional practices. The lack of responsiveness to local traditions, distance, cost of travel and perceived indirect costs were reported as barriers to attend health facilities for childbirth. Most informants appreciated improved quality of birth care provided by the midwives. The limited presence of midwives in their assigned village, and difficulties contacting them during labour were reported by many community informants as what hindered midwife use at childbirth. Some differences exist between the two districts which affected the midwives and TBA service delivery: in Cianjur TBAs receive greater incentive and are more empowered, whereas in SW Sumba TBA practice is not formally permitted under the recent maternal health revolution initiative and incentives provided to midwives through the new health insurance schemes are not consistently applied. Conclusion: Strategies to get midwives to reside in villages, easier contact and community health education strategies to address cultural practices could increase midwife use and health facility attendance for childbirth. Formulating ways to improve collaboration between TBAs and midwives could benefit pregnancy outcome in rural Indonesia.
Analyzing key influences over actors' preferences and use of evidence in policy development: insights from the Nigerian IMNCH strategy

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ABSTRACT

Background: Evidence-based policymaking has been promoted as a means of ensuring better outcomes but what counts as evidence in policy making lies within a spectrum of expert knowledge through scientifically generated information. Different actors provide varying degrees of support for and use of different types of evidence in policy development. Since not all forms of evidence share an equal validity or weighting for policymakers, it is important to understand the key factors that influence their choice of evidence. Method: A retrospective cross-sectional study was carried out at the national level in Nigeria. Case-study approach was used to select the Nigerian Integrated Maternal Newborn and Child Health (IMNCH) strategy. Policy analysis framework was used to explore the key contextual and participatory influences on choice of evidence in developing the strategy. Data was collected through review of relevant national documents and in-depth interviews of key policy makers. Thematic analysis was applied. Results: Breadth of evidence used was wide, ranging from expert opinions to systematic reviews. The choice of different types of evidence overlaps across actor categories. Key influences over actors' choice of evidence were: (i) perceived robustness of evidence - comprehensive, representative, recent, scientifically sound; (ii) roles in evidence process, i.e. their degree and level of participation in evidence generation and dissemination, vis-a-vis their role in the policy process; and (iii) contextual factors such as global agenda and influence, timeline for strategy development, availability of resources for evidence generation, and previous unsuccessful policies/plans. Conclusion: Actors' choice of evidence in policy making is influenced not only by the characteristics of evidence, but on their parts in the process, their power to influence the policy, and the context in which evidence is used. Significance: High level of significance.
The combined influence of different groups of national actors on evidence-informed health policy development: case study from India and Nigeria

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ABSTRACT

INTRODUCTION: Health systems operate within broader social, political and economic contexts. A focus on people-centred health systems acknowledges that people are at the heart of health system complexity and can influence health system performance, resource allocation, organization of health services and policy change. Despite existence of theoretical frameworks for understanding policy change, limited research explores the combined roles of different national actors in evidence-informed policymaking in low and middle-income countries. This presentation examines the collective influence of government, civil society organizations, researchers and health workers on evidence-informed policymaking in India and Nigeria.

METHODS: We analysed three policies in each country: internationally-'prominent'; internationally-'neglected' and health systems policy. Qualitative data was collected using document reviews and in-depth interviews with policy actors and analysed using framework approach. RESULTS: Five of seven groups of policy actors interviewed for this study were national actors: government, civil society, researchers, health workers and the media. The remaining two were influential donors and tobacco industry. Two arms of government in both countries influenced policy decisions: political leaders used international treaties to initiate health reforms which were responsive to needs of the public, while bureaucrats commissioned evidence for policy. In India, civil society organizations advocated for rights of vulnerable people and presented evidence for organizing health services. In Nigeria, researchers working in research institutes set the research agenda while health workers generated evidence for policy development. Overall, research participants perceived all policies to be evidence-informed DISCUSSION: Whereas the individual participation of different national actors had equivocal influence on uptake of evidence, our findings suggest that the collective participation of a range of national actors contributed to evidence-informed policymaking. Involvement of diverse groups of national actors could also stimulate responsiveness to the rights and health needs of the public as a way of strengthening people-centred health systems in different contexts.
The health city movement in China: A people-centered approach

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ABSTRACT

Background: The health city project (HCP) in China contains four core items: environment improvement, health promotion, food safety and drinking-water, and communicable diseases control. Until now, it has been developed for 24 years and a total of 153 cities have been named as health city. The purpose of this research was to explore the impacts of HCP. Methods: Retrospective cohort study design was adopted in this research. Data were collected from 15 health cities and 15 corresponding control cities, ranging from the 5th year before health cities being named to 2012. 16 residents and 12 key-informants in each health city were interviewed using semi-structured interviews in December 2013. Quantitative data were analyzed using descriptive statistics and qualitative data were analyzed manually according to pre-defined themes. Results: Most health cities have greatly improved its environment and infrastructure, particularly garbage and sewage disposal, greening space, road condition and Agri-product market. Urban residents’ health literacy was tremendously increased, blood and sexually transmitted communicable diseases and vector-borne diseases were decreased to or maintained at a relatively low level. Awareness of environment-health links was raised across residents and stakeholders. Inter-sectoral collaboration and cities’ capacity of governance was remarkably strengthened. Many health cities also announced several municipal policies to maintain the achievements. Discussion: Health is determined by health environment, which means that health issues are beyond health system. Because improving health environment needs other sectors' participation, or even the public’s. HCP in China mobilized considerable resources to improve urban residents' working and living conditions, achieved effective intersectoral collaboration and promoted communities' involvement. What's more, many health cities have put health issues onto urban agendas. The findings would contribute to better understanding health promotion and health in all policies, and could also provide valuable experience for other developing countries.
What types of international partnerships are most valued by Kenyan and Tanzanian universities for increasing health research capacity?

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ABSTRACT

Background Human resource development for health care, policy, and research is critical to stronger health systems. International partnerships are a commonly applied approach to health education and research capacity building of universities in sub-Saharan Africa. Guidelines and good practice documents exist to guide participants in formulating and managing partnerships. However, comprehensive and contextualized assessments of the range of partnerships of different universities, their objectives and outputs, characteristics of the most and least valued partnerships and how they actually support research capacity building are scarce.

Methods This study examines international partnerships in medicine, nursing and public health at two universities in Kenya and two in Tanzania through review of documentation at host universities, partners and government ministries, key informant interviews, focus group discussions with students and faculty, and participant observation.

Results The characteristics of over 90 partnerships were mapped and analysed. More than 75% linked the African universities with European and North American universities. These North-South partnerships were reported as the most valued despite increasing calls for South-South partnerships. Many partnerships focus on research, although relatively few focus directly on research capacity building of host institution representatives. Sandwich PhD programs where participants spend time in both high-income and low-income institutions were repeatedly identified as highly beneficial by the participants. Sandwich programs allow developing researchers significant time to write independently and bridge cultural differences.

Discussion/Conclusion Many partnerships between universities in high-income countries and universities in Kenya and Tanzania fail to develop the capacity of the African partners significantly. In some cases greater research capacity may be built at the high-income countries. Greater research capacity of African partners may be built through partnerships that focus directly on research capacity building. How these programs are designed is crucial. Sandwich models are promising but may offer high-income countries too little to merit investing in them.
Distributed district leadership to select health workforce and system bundles for improved service delivery in three Tanzanian districts as part of perform project

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ABSTRACT

Introduction Strengthening workforce performance in a people-centred district health system is a complex and context-specific leadership task which requires expertise to develop strategies appropriate for a particular context. Distributed leadership (DL) may address this need and use the capacity of the district team to improve workforce performance. DL is defined as a system of practice where leaders and followers share leadership tasks in a structured situation using a variety of tools. Our action research (AR) study supports decentralised district teams to improve workforce performance. Methods Council Health Management Teams (CHMTs) based in an urban, semi-urban and rural district from Iringa region were selected as study sites. A Country Research Team (CRT) supported the CHMTs to carry out a situation analysis and select Human Resources (HR) and other Health System (HS) strategies as bundles. AR tools were developed for problem analysis and identification, selection, planning, implementation, monitoring and evaluation (M&E) of these HR/HS bundles. This process took place in an environment where each district leader was asked to mobilize the capacity of the CHMT. Results Members of each CHMT analysed and prioritised workforce performance problems based on agreed criteria for the development of HR/HS bundles. These bundles were examined for synergistic and antagonistic effects, selected, translated into action plans with indicators for M&E and nationally available resources were identified for implementation. The bundles are being implemented and regularly reviewed. One bundle example is local staff recruitment, supportive supervision, staff training and incentives, supply management and infrastructure upgrade to improve quality and coverage of HIV counselling, treatment and care services. Discussion AR may facilitate the emergence of DL in a complex adaptive district health system. Preliminary results indicate some enhanced capability by the CHMTs to analyse and address complex health system issues. This needs to be confirmed by improved service delivery outcome.
Does the Tanzanian health policy dialogue allow for country ownership and mutual accountability between development partners and the government?

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ABSTRACT

Background: Development Partners (DPs) and the Government of Tanzania (GoT) have worked under a health Sector-Wide Approach (SWAP) with a common policy, expenditure and institutional framework since 1998. Under this framework they undertake joint planning and accounting for resources. The aim of this study is to explore the concepts of country ownership and mutual accountability in decision-making by characterising the institutional factors, including the incentives of the institutions and individuals involved in the SWAP policy dialogue, as well as the political context within which the dialogue takes place. Methods: A stakeholder analysis was conducted through in-depth interviews with DPs, government and civil society representatives, document review and non-participant observation. A political-economy framework was subsequently developed to analyse the incentives, power and political context underlying the decision-making process of the SWAP. Results: Processes for joint decision-making and accounting for resources were successfully set up. However, the structure of the SWAP is technocratic, excludes some important stakeholders in the Tanzanian health sector, and hence does not fully reflect the political context and power dynamics involved in the SWAP policy dialogue. Over time, there has been fatigue and disengagement with the SWAP amongst key donors and the GoT. Discussion: The international community should engage in the SWAP as a process of institutional reform as opposed to just a technocratic solution to development assistance. Any change of approach should be flexible, step-wise, and avoid the cyclical patterns found in the international community's approach to engaging with governments. More research is needed to further integrate political and economy elements of frameworks in order to deepen our understanding of institutional reform and improve the SWAP policy dialogue. This study contributes to the complexity science and people-centred systems research topic by identifying the complex relationships and political context of the agenda-setting process of the Tanzanian health SWAP.
Effect of quality improvement approach on immunization coverage in rural Zambia

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ABSTRACT

Background Low immunization coverage in some rural districts is one of the challenges affecting child health programmes in Zambia. We determined the factors contributing to low immunization coverage in Gwembe district and used quality improvement principles to increase facility immunization coverage. Methodology In February, 2013, the District Health Management Team conducted performance assessment to the health centres to determine the causes of low immunization coverage. Due to logistical challenges, only 9 out 13 health facilities were assessed. The team focused on immunization data for 2012. Under five registers were reviewed. Data from the registers was compared with immunization reports submitted to the district during the same period. Results Most of the data from the under five registers did not correlate with the district reports. Furthermore, most health facilities had low immunization coverage (range, 56% to 70%) and Munyumbwe RHC had the lowest fully immunization coverage (56%), with BCG showing the lowest coverage (67%). The main reason for the low BCG coverage was that many mothers were being sent away with their children without receiving the BCG vaccine. This was because nurses could not open the BCG vaccine vials to avoid wastage as the number of children was below the required 20. The district quality improvement team embarked on a six months program to provide technical support and mentorship to Munyumbwe facility staff. Focus areas included data management, increasing the number of days for BCG to twice a month, sensitizing the community on BCG days, monthly monitoring of child health immunization coverage. After six months, fully immunization coverage for the centre increased from 56% to 86%. Conclusion Our findings suggest that health system factors contribute to low child immunization coverage and use of quality improvement principles can help improve immunization coverage and lead to improved child health outcomes.
Dynamic analysis of a chinese hospital with the huge size of outpatients and emergency visits from 2005 to 2013

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ABSTRACT

Background: The First Affiliated Hospital of Sun Yat-sen University is an important base for research, medical service, medical education, preventive care and rehabilitation in South China. It is well known for its high quality and excellent service in China and Southeast Asia. As one of the highest outpatient and emergency visits hospital in China, annual visits amount have exceeded 4.8 million, the peak daily visits have reached 22,365. Forecasting the trend of outpatient visits can help the expert of healthcare administration to make a strategic decision. If the trend could be forecast accurately, it would provide the administrators of healthcare with a basis to manage hospitals safety and effectively, to make up a schedule for human resources and finances reasonably, and distribute hospital material resources suitably. Thus, to ensure the safety of patients.

Method: By sampling monthly amount of outpatient from Jan. 2005 to Dec. 2013, the trend of the time series was analyzed and calculated the seasonal index of the amount of hospital outpatient and emergency visits with the use of long-term trends elimination method. Result: The flow law of patients in the Hospital outpatient and emergency is significantly affected by seasonal factors, and different month has its own variation character. The seasonal indexes are the highest in March, July, August, November and December (seasonal index - 105%), while the lowest in January, February, October (seasonal index - 95%). Conclusion: According to the patient flow law of outpatient and emergency visits, we can make reasonable optimal allocation of medical resources and provide evidence for the scientific decisions of hospital management. Measures can be described as shaping three-level patient transferring system, optimizing outpatient layout and process, implementing GP outpatient, setting outpatient consultation center to improve outpatient medical quality and give some reference for outpatient management in large general hospital of China.
Pneumonia diagnostics - the search for new tools for frontline health workers in resource poor settings.

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ABSTRACT

Background Globally, pneumonia remains the leading cause of death in children under five. Diagnosis primarily involves respiratory rate assessment, which can be challenging given the current available tools used by frontline health workers in resource-poor settings. Through funding from the Bill & Melinda Gates Foundation, Malaria Consortium is conducting the first of its kind, large-scale evaluation project to identify the most accurate, acceptable, scalable and user-friendly diagnostic tools for the respiratory rate measurement and oxygen saturation for diagnosis of pneumonia in children by community health workers (CHWs) and first-level health facility workers in four low-income countries; Cambodia, Ethiopia, South Sudan and Uganda. Methods The study involves quantitative and qualitative methodologies. After a comprehensive landscape review involving over 150 possible devices, a panel of experts select twelve diagnostic tools to be analysed, ranging from simple counting devices to sophisticated mobile phone applications and pulse oximeters. Qualitative stages of the study will document 250 CHWs’ experiences of using the different devices, and perceptions of the parents of children assessed using the new tools. The quantitative elements measure the devices accuracy and compare this to agreed gold standard measures. Data analysis will focus on measuring positive and negative percent agreement, as well as agreement in respiratory rate measurement and oxygen levels. Results The findings will highlight the most appropriate and accurate diagnostic tools for assessing children for uncomplicated and severe pneumonia in rural areas in low and middle income countries. Furthermore, the research findings will document the perceptions of frontline health workers and caregivers/parents on the acceptability and usability of the devices. Discussion Through the identification of new diagnostic tools for pneumonia, the research findings will help to improve the quality of care for children with pneumonia in resource-poor settings. Furthermore, through improved diagnostics, the study will strengthen rational use of antibiotics by providers.
Applying the responsive regulation pyramid to assess quality of care regulations for patient safety in India

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ABSTRACT

Background: Quality of care (QoC), a cornerstone for people-centred health systems is often an unfortunate casualty in countries with weak regulatory environments, such as India. Much of the research on regulation of QoC in India and comparable low and middle income countries (LMIC) is focused on analyzing specific regulatory instruments, and little is known about how the regulatory architecture operates in its entirety across a geopolitical unit. We applied the Ayres and Braithwaite ‘responsive regulation’ framework to analyze the strengths and weaknesses of regulation for QoC in India. Methods: The responsive regulation framework proposes a hierarchy of policy instruments, from the persuasive (frequently applied) to the punitive (rarely applied). Existing regulatory policies for QoC at the federal level and in two states ’Madhya Pradesh and Delhi’ were enlisted, and in-depth interviews conducted with regulators to assess the extent of their implementation. The findings ‘maps of the regulatory architecture in the two states’ were evaluated using the responsive regulation framework. Results: Application of the framework revealed considerable gaps in design of regulatory provisions at the federal level. There is also a near absence of provisions at voluntary and meta-regulation in both states. Persuasive mechanisms for improving quality of purchased are widely deficient. Voluntary accreditation has poor coverage, and continuing professional education is largely non-existent across both states. On the other hand, punitive mechanisms suffer from the lack of financial and human resource capacities of regulatory organizations. Frequent contestation of standards by medical bodies has led to dilutions. Revocation of licenses of registered providers is rare, as are actions against unqualified practice. Discussion: The responsive regulatory framework reveals significant gaps in the design and implementation of QoC regulations in India. There needs to be a concerted effort to strengthen the entire spectrum of regulatory mechanisms - from the persuasive to the punitive.
The coverage of non-communicable diseases in the primary healthcare network in the Democratic Republic of Congo (DRC). The case of type 2 diabetes in Kinshasa

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ABSTRACT

Background. DRC is experiencing an increase in the morbi-mortality related to Non Communicable Diseases (NCD). An adjustment of DRC health system, based on Health District model, is needed in order to tackle this public issue. This article used International Diabetes Federation (IDF)'s guidelines to assess the capacities, the knowledge, and the practice of type 2 diabetes (T2D) care of healthcare facilities (HF) belonging to the Kinshasa primary health care network (KPHCN). Methodology A multicentric study was conducted in 18 HF of KPHCN in charge of the follow-up of approximately 5874 diabetic patients. The presence of IDF recommended materials and equipment were checked and 28 health providers were interviewed about their theoretical knowledge about patients management and therapeutic objectives during recommended visits. Chi square test or Fisher exact test were used to compare proportions and the Student t-test to compare means. Findings The integration of NCD healthcare in the KPHC network is effective. The majority of HF possessed IDF recommended materials except for the clinical practices guidelines, urinary test strips, monofilament, available in only 1, 2 and 4 HF, respectively. KPHCN referral facilities had required materials for biochemical analyses, the ECG and for the fundus oculi test. Patients' management is characterized by the lack of attention on the impairment of renal function during the first visits and a weak respect of the recommended practices during the quarterly and annual visits, A weak knowledge of the reduction of cardiovascular risk factors-related therapeutic objectives. Conclusion. The capacities, the knowledge, and the practice of T2D care were poor among of HF of KPHCN. The lacking equipment and training of healthcare professionals should be supplied even to those who are not medical doctors. Special attention has to be put on the clinical practice guidelines formulation and sensitizing and on supervision.
Improving access to essential medicines at health facilities through engagement of the district leadership - Experiences from Uganda

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ABSTRACT

Background: To accelerate quality and safety improvements, the MOH Uganda developed the National Quality Improvement Framework and Strategic plan (QIF&S) 2010-2015 which provides a common framework for all health institutions, partners and stakeholders to coordinate, plan, implement, monitor and evaluate quality improvement initiatives. The national quality improvement (QI) framework encourages formation of QI coordination structures at various levels of the health system with specific roles and responsibilities. At the district level, a District Quality Improvement Committee (DQIC) is expected to be established with the overall responsibility of directing QI implementation within the district. Method With support from USAID Applying Science to Strengthen and Improve System (USAID ASSIST) project, Kabalore DQIC was formed in 2012. Frequent stock out of essential medicines in the health facilities mainly due to delayed drug orders came to the attention of the DQIC. In February 2013 the DQIC improvement aim was to improve timely ordering of medicines focusing on ART. A District Health Team (DHT) member was assigned to lead improvements efforts for this project. Consequently other changes were introduced. These included; distributing the drug order schedule to all heath facilities, sending SMS reminders to health facility in charges two weeks to the ordering deadlines, conducting a training on using patient load data for drug quantification, and providing regular feedback to facilities on their performance. Results Following the interventions the proportion of health facilities submitting drug orders timely raised from 43% (10/23) in December 2012 to 87% (20/23) in December 2013 and in addition there were no stock out of key HIV care medicines at any of the 23 HIV care centers during the last quarter of 2013. Conclusion Simple and inexpensive changes by health system leaders can lead to significant improvements in the delivery of services to the patients especially in the resource constrained low income countries.
Our sisters do not have to go too far': A provider-centered health systems approach for post-abortion care

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ABSTRACT

Background Re-organizing post-abortion care (PAC) services to provide FP counseling and contraceptives at the same location as treatment improves contraceptive uptake and reduces repeat unintended pregnancy. Burkina Faso, Senegal, Guinea and Togo, implemented such PAC programs. Programmatic emphasis was on FP services and counseling at point of care, advocacy with Ministry of Health stakeholders, training, availability of MVA kits and FP supplies and integrating PAC indicators in health information system. Methods A qualitative study was conducted for a provider-centered understanding of program implementation contextual issues. We conducted 52 in-depth interviews (IDIs) among policy makers and program champions; 14 focus group discussions (FGDs) among service providers; and reviewed PAC clinic registers (January 2008 - June 2012). The IDIs and FGDs were transcribed (in French), translated (in English), and thematically coded. The collated thematic data from the three sources (IDIs, FGDs and clinic registers) were independently analyzed and subsequently triangulated. Results Guinea and Togo, FP supplies available, had high uptake whereas Senegal and Burkina Faso had low uptake (clinic registers). The most serious issue is unavailability of all family planning products at the manual evacuation room (IDI,Senegal). Unavailability of MVA kits in facilities was perceived detrimental to morale. The main idea is to bring PAC services closer to our sisters so they do not have to go too far to get them (FGD,Togo). Monitoring was inadequate - If we had been able to continue monitoring, we could know what was actually done so far. But unfortunately, we have not been able to keep track (IDI,Togo). Conclusions PAC program implementation is fraught with HSS issues - a policy and provider centered approach that addresses the HSS six building blocks are essential. Study design (IDIs, FGDs and clinic registers) and analytic approach shed light on the successes and bottlenecks that policy makers and service providers confront when emulating for a people-centered health systems approach.
A confidential enquiry into child deaths in Uganda and Mali: learning from every death

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ABSTRACT

Background: A confidential enquiry is a way to identify avoidable factors in the health system and beyond, which have contributed to deaths, without blaming anyone. Such confidential enquiries are not yet widely used in Africa. Methods: All child deaths occurring in two rural subcounties and one urban parish of Uganda and two rural areas of Mali have been reported by village health teams and investigated by field workers, over a period of at least 24 months. Fieldworkers interviewed parents and health care workers and the cases were reviewed at a multidisciplinary panel meeting involving local health workers and VHTs. The panel agrees on most likely cause of death, identifies avoidable factors and makes relevant recommendations. The study team implements and/or follows up implementation of recommendations. Results and Discussion: In over 95% of deaths, at least one avoidable factor was identified, which included both missed opportunities to prevent diseases, and inadequate treatment. Poor quality of care was an important factor in many deaths, so recommendations were made and implemented to address this, including discussion of cases and continuing education of health workers at every level. From the first to the second year of the enquiry, child deaths have reduced by 20-25% in each of the study areas. Conclusions and recommendations: The confidential enquiry is adaptable to the developing world. The process was associated with a reduction in under-five child mortality, and with improved quality of care in health facilities. This study was done under Human resources for primary health care in Africa (HURAPRIM) collaboration funded by European Union under contract 265727
Promotion of better complimentary feeding practices: results from a randomized control trial in rural Bangladesh

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ABSTRACT

Background & objectives: Appropriate infant-feeding practices and nutritional status are interrelated. Prevalence of malnutrition sharply rises within 12 months of age of infants in most developing countries which coincides with the period of complimentary feeding (CF). This study examines the effects of intensive counseling on promotion of appropriate CF practices, controlling for infant and maternal characteristics in rural Bangladesh Method: We conducted a randomized control trial of an educational intervention in Matlab, Bangladesh where icddr,b provides MNCH-FP services in four blocks since late 1977. Two blocks were randomly assigned to the intervention group and the rest to the control group. One eighty mother-infant pairs were enrolled as infants aged 6 from each group. The mother and the family members of the intervention group received intensive counseling by community health workers at 6, 8, 9, 10 and 12 month of infant age. Information on infant feeding practice and maternal characteristics was collected from both groups. Continued breast feeding, bottle feeding, initiation of CF, food frequency, meal frequency and food diversity were considered in CF index calculation and for harmful, positive and in between practices scores were assigned 0, 2, and 1 respectively. Descriptive statistics and logistic regressions were used to examine the effects of the counselling Result: In the intervention 68% of the mothers scored 17 or more (better) compared 32% in the control group (p<0.001). Other factors associated with better CFI for intervention group were higher frequency of counselling (OR: 14.0; 9.0-22.8), Hindus and other religion (OR: 4.3; 2.5-7.5), and maternal education 5 years or more (OR: 3.5; CI: 1.8-7.0). Whereas in comparison area no pattern of association was observed with better CFI Conclusion: The counseling promotes appropriate CF practices. Covariates of appropriate CF practices should be considered while designing IYCF intervention in Bangladesh. Significance for the selected field-building dimension: The computed CFI provides opportunity for comprehensive evaluation of a nutrition programme.
Government tablets have less power': people's perspectives on utilization of public healthcare in rural India

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ABSTRACT

Background India has been called the 'world's pharmacy', supplying life-saving drugs to many countries. However, little is known about the quality of medicines available in the Indian market. In addition to quality, people's perceptions about medicines are crucial in ensuring access and utilization of public health services. This study is an attempt to understand patients' perspectives about medicines in government services and to explore if this explains the relatively poor utilization. Method We used data from a WHO-Alliance funded study on access to medicines in Tumkur district, Karnataka. Data were collected using mixed methods; we conducted nine focus group discussions among community members and health workers. We also used semi-structure questionnaire data from a household survey (n=813). Results We found that most (82%) rural households obtained outpatient services from private health facilities. One of the main reasons was related to a perception that the costlier the medicine, better the quality (91%). The most striking finding was the predominant negative perception on medicine quality in public services: 'Government medicine has less power' and 'they do not produce fast results'. Health workers reported that private providers strengthened this negative perception during their consultation thus creating a self-reinforcement for seeking care in private facilities. A large proportion of respondents (67%) reported they were unsure of the quality of medicines supplied in public facilities. Conclusion Community perceptions on medicine quality could be a major barrier in influencing choice of healthcare sought by patients. Our findings suggest that improving availability of medicines in health facilities in India may not improve utilization of care. Indian policymakers need to improve medicines quality regulation and make the results widely available. Ensuring availability of good quality medicines in public facilities is an important step towards building a people-centred health system and Indian regulators need to respond to the poor perceptions on medicines in public facilities.
Opportunities to improve postpartum care for mothers and infants: development of context specific packages of postpartum interventions in rural districts in four sub-Saharan African countries

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ABSTRACT

Background: Most maternal and under-5 deaths occur in the postpartum period. However, improvement in postpartum service delivery has been neglected. We use health systems research approach to examine how postpartum services should be best organised in order to reduce maternal and infant mortality and morbidity. Our project is implemented in rural districts in Burkina Faso, Kenya, Malawi and Mozambique. This study describes the process of selecting context-specific packages of postpartum interventions having potential to improve maternal and infant health. Methods: First, potential postpartum care (PPC) interventions were designed based on data provided through (1) critical review of maternal, newborn and child health (MNCH) policies in study countries, (2) quantitative situation analysis of existing MNCH services and care at the four sites, (3) consultation of stakeholders, and (4) existing knowledge regarding PPC. Secondly, interventions thus designed were discussed at each site with stakeholders, refined and final site-specific package of interventions was selected and accepted for implementation. This whole process took place between end-2011 and mid-2013. Results: In all study countries MNCH is national priority but specific PPC policy is weak. There was very little evidence of effective PPC implementation. In the study districts most women didn’t receive PPC during the first week after childbirth (25% in Burkina Faso, 33% in Kenya, 41% in Malawi, 40% in Mozambique). These assessment findings resulted at each district in selection of context-specific interventions with the aim to improve PPC and the consequent potential to decrease maternal and infant mortality and morbidity. These interventions could be broadly classified in three groups; (1) facility-based interventions strengthening existing facility-based PPC, (2) interventions facilitating PPC by integrating this care within other services, and (3) community-based interventions. Conclusion: Health system research identified extensive gaps in availability and provision of PPC and context-specific packages of interventions having potential to improve PPC.
Individual and organizational factors associated with use of personal protective equipment by Chinese migrant workers exposed to organic solvents

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ABSTRACT

Background: As the important drivers of China’s economic growth, small- and medium-sized enterprises (SMEs) have a huge demand for labor which cannot be met by local population alone. Thus, a sizable contingent of the workforce for SMEs comprises rural-to-urban migrant workers (about 230 million in 2012). Since SMEs are less equipped to deal with occupational health and safety (OH&S) issues, migrant workers, who are more likely to work in SMEs than large enterprises, are disproportionally exposed to occupational health hazards. OH&S is therefore a significant concern for migrants and an imminent policy challenge for sustainable regional economic development. Wearing personal protective equipment (PPE) during work is the most direct and efficient measure of preventing occupational diseases. However, the use of PPE among migrants is rarely studied in China. Our study aimed to examine both individual and organizational factors associated with Chinese migrant workers’ compliance with PPE use and to determine the relative importance of these factors. Methods: Data were collected in 2012 through a cross-sectional survey including 907 rural-to-urban migrants exposed to organic solvents working at SMEs in the Pearl River Delta Region (PRDR). Health Promotion Model (HPM) was used as a theoretical framework to examine the predictors affecting PPE use. Analysis was performed using two-level logistic regression. Results: For the use of face mask, after controlling for other variables, higher scores on social models and interpersonal support were significant predictors for greater PPE use, with OR 1.24 (95%CI: 1.13~1.35) and OR 1.14 (95%CI: 1.03~1.27). In addition, after controlling for other variables, higher social models and social norms were significant predictors of gloves’ use, with OR 1.36 (95%CI: 1.23~1.50) and OR 1.19 (95%CI: 1.09~1.32). Conclusions: Priority should be given to enhancing social modeling, social norms and interpersonal support as a strategy to improve migrant workers’ compliance with PPE use.
Addressing rational use of medication in pediatric patients with respiratory tract infections (RTI) through improvement collaborative in Georgia

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ABSTRACT

Background Respiratory Tract Infections (RTIs) contribute to 51% of registered illness among children in Georgia. There are effective interventions to cure RTI but appropriate care remains very low. To improve the quality of care of pediatric RTIs, the USAID Health Care Improvement Project supported a collaborative improvement intervention in 17 ambulatory clinics and village practices and 3 hospitals in Imereti Region of Georgia. Methods In 2012, improvement teams made up of managers and medical personnel were created in each facility. The project supported these teams with intensive clinical and improvement trainings, development and distribution of job-aids and other evidence-based tools on RTI management. Improvement teams identified quality gaps and introduced an RTI change package focused on essential, high-impact, cost-effective interventions. Teams at the facilities introduced the changes in their local health care processes, including routine peer medical chart review, case study discussions and regular review of evidence-based medical literature. To measure the impact of QI activities, prospective non-randomized assessment was conducted in intervention and control facilities before and after the project interventions. Control group was comprised with the same type and number of facilities in Tbilisi, Imereti and Achara Regions with no project interventions. Results After 18 months of project QI interventions, chart review assessment revealed significant attributable difference between participant and control facilities in following key measures: - % of medical charts with first choice antibiotic increased by 71% (p<0.001) in ambulatories and 33% (p<0.001) in hospitals; - Average number of non-evidence-based medications prescribed decreased by 2.6 (p<0.001) in ambulatories and 6.1 (p<0.001) in hospitals; - % of medical charts administered short-acting methilxantines/euphilin in hospitals decreased by 67% (p<0.001). Conclusions Scale up and institutionalization of proven QI methods/tools countrywide most likely will lead to decreased antibiotic resistance, death and disease burden among children and cost-savings for payers.
Cost of implementing an electronic clinical decision support system for maternal health care: case of Tanzania rural primary health centres

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ABSTRACT

Background: Existence of a 'know-do gap', whereby health workers do not perform to the best of their knowledge, has contributed to poor quality of maternal care and outcomes in Tanzania. In an effort to bridge the gap, an electronic clinical decision support system for maternal health was piloted in six rural primary health facilities in Tanzania envisaged to improve the quality of care through enhanced provider motivation and performance. Aim of this study was to provide a cost assessment of the proposed system for routine maternal health care. Methods: This retrospective study was conducted in Lindi rural. Start-up and implementation costs incurred by the project were analyzed using ingredients approach. These costs broadly included vehicle, equipment, personnel, training, communication, office supplies and consumables. Results: Total financial cost of implementation amounted to 302,138.87USD. 85% of these costs were incurred in the start-up phase and included all the activities in preparation of the actual implementation of the system for patient care. Start-up cost was mainly driven by capital and personnel inputs. Recurrent cost made up 82% of total cost. Personnel made the largest share of costs (47% of total cost and more than half of the recurrent cost) followed by training. Annuitization of capital cost showed a total cost difference of 11% between the economic and financial cost. Financial and economic costs per woman were 101.12USD and 89.78USD respectively; however, when only training and equipment costs were considered, these costs fell to 22.27USD and 20.73USD respectively. Economic costs were slightly sensitive to discount rate. Conclusions: The program cost information obtained is very useful in guiding system adoption and scale-up to other health facilities within Tanzania and other developing countries. Cost figures justify adoption and scale-up of the system; however, full cost-effectiveness analysis will be carried out for assessment of its efficiency.
Barriers to utilization of antenatal diagnostic tests in Senegal. A qualitative study from the perspectives of health providers and clients

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ABSTRACT

Background Under-utilization of laboratory tests undermines the quality of health care delivery. We identified barriers to utilization of standard antenatal tests in Senegal to inform interventions improving the quality of antenatal care (ANC). Methodology We defined test utilization to include: test request, execution, and usage for subsequent prescriptions. Data collection was multi-level, using mixed methods: ethnography in laboratories and ANC clinics at 2 hospitals and 2 health centers across 4 regions; survey amongst 106 pregnant women undergoing ANC tests; in-depth interviews with 80 pregnant women and family in communities. Findings Midwives’ ANC test request decisions were based on own judgment, resulting in both over- and under-prescription (e.g. drepanocytosis testing in two-thirds of multi-para; no syphilis screening in one-quarter of clients). Reasons for under-prescription included midwives assuming women’s financial problems, and relying on clinical symptoms only. Midwives didn’t always explain reasons and conditions for tests or take results into account when prescribing drugs. Laboratories were adequately equipped and supplied for ANC testing. Average cost of the ANC standard package was 13 Euro. Test results were available only the next day in three laboratories, entailing extra client cost. Near to all community members considered ANC important. 40% of women delayed first ANC visit, mainly out of fear of costly prescriptions. One-third of community women had no lab test when pregnant - either because they had no ANC, no test request, or didn’t take the request to the lab for financial reasons. Discussion High cost and midwives’ decisions were the main barriers to ANC test utilization. Midwives act as gatekeepers, limiting access to both testing and laboratory results-informed treatment. To meet the needs of midwives and women alike and increase utilization of ANC testing, we recommend development and availability of clear national guidelines on ANC test package and reduction of ANC testing cost.
How do women judge the quality of obstetric care?
Determinants of women's ratings of quality of obstetric care in rural Tanzania

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ABSTRACT

Background: Patients’ reported opinions of the health system need to be collected and understood in order to provide patient-centered care. We investigated determinants of women's ratings of the quality of care experienced during their most recent delivery. Methods: We conducted a census of all deliveries in the 6 weeks to 12 months preceding the survey in clusters served by 24 primary care clinics in rural Pwani Region, Tanzania. All women delivering in one of the study facilities were included in this analysis. We interviewed women about demographic and obstetric factors and the quality of their obstetric care using a structured questionnaire. We created a summative composite index of perceived quality from six quality questions. We also assessed the functioning of the local health clinic. We used a multi-level model to analyze factors associated with women's ratings of the quality of care received during delivery. Results: Of the 848 respondents, 116 (14%) rated the overall quality of care received during their delivery as excellent. Quality composite score results ranged from 7-30, out of a possible 30. In multivariable analysis, women who listened to the radio daily reported lower quality composite scores (OLS: -1.06, p<0.001). Women who reported receiving more services in ANC had higher quality composite scores (OLS: 0.58, p<0.001) as did women receiving more delivery services (OLS: 0.28, p=0.045). Women who reported disrespect and abuse during delivery had significantly lower quality scores (OLS: -4.38, p<0.001). Conclusions: Women's experience with the health system prior to the current visit (in ANC) and the content of the current visit are the largest determinants of her rating of quality. Health system indicators, such as infrastructure availability and provider knowledge, did not influence ratings of quality. Focusing on improving the process rather than inputs of service delivery during ANC visits and delivery may increase actual and perceived quality of care.
Ethical dimensions to care, cure and communication in patient provider partnerships

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ABSTRACT

Purpose There is a yet to be unravelled need for a deeper understanding of the multi-layered nature of contextual barriers to effective communication in provider patient relationships. Risk-reduction, preventive behavior, care and cure in the continuum of disease require not just a simple listing and delineation of identified barriers, but an ongoing spectrum of sensitivity to the challenges they pose within specific contexts. This nuanced understanding can better support the implementation of a more informed set of ethical guidelines for patients and participants. The guidelines can in turn pave a path for people centric and participatory resolutions in health interventions, programs or service provision that promote health. Focus This abstract has been drawn from more than a decade of research association with low income communities in the states of Karnataka and Tamil Nadu, India through studies designed to study the linkages between economic, social and individual vulnerability in reproductive and sexual health decisions women make. Ranging from mixed methods studies to randomized controlled trials the shared aims of these studies were to better understand health behavior among women living in limiting circumstances and to create sensitive and appropriate health promotional strategies for them. Significance The paper will present the opportunity that lies in service provision in the form of effective communication methods in patient provider relationships in settings of constraint. Understanding the role of enabling communication in this continuum can facilitate the creation of a few universal guidelines that also offer the scope for customized protocols that address the complex needs of an identified audience at the individual, social and systemic levels. Communication can be a valuable skill, science and process by which the partnerships can be more efficacious with audiences that have distinct and diverse requirements in health behavior and decision-making.
Increased institutional birth coverage does not mean improved skilled birth attendance: Study of intra-partum care in JSY cash transfer program in Madhya Pradesh, India

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ABSTRACT

Background: Access to facility delivery in India has significantly increased with the Janani Suraksha Yojana (JSY) cash transfer programme to promote institutional births. However decline in maternal mortality has only followed secular trends as seen from the beginning of the decade well before the program began. Hence it is important to examine the quality of intra-partum care provided in facilities under the JSY programme.

Methods: (i) Non participant observations (n=18) of intra-partum care during vaginal deliveries at a representative sample of 11 facilities in Madhya Pradesh to document what happens during intra-partum care (ii) Interviews (n=10) with providers to explore why the care is so. Thematic framework analysis was used.

Findings: Three themes emerged from the data: (i) Staff failure to provide routine skilled care: this emerged from observations that monitoring was limited to assessment of cervical dilatation, lack of readiness to provide key elements care, and the execution of harmful / unnecessary practices coupled with poor techniques (ii) Dominant staff, passive recipients: staff sometimes threatened/abused or ignored women during delivery, women were passive and accepted this hierarchy. Attendants served as ‘go betweens’ between women and providers (iii) Delivery environment is chaotic: Delivery rooms were not conducive to safe delivery provision and coordination between providers was poor. The interviews with providers revealed their awareness of the compromised quality of care, but they were constrained by structural problems. Positive practices were also observed, including companionship during childbirth and women mobilizing in the early stages of labour.

Discussion: Our observational study did not suggest an adequate level of skilled birth attendance. The findings reveal insufficiencies in the health system and organisational structures to provide an ‘enabling environment’ for skilled birth attendance. We highlight the need to ensure quality obstetric care prior to increasing coverage of institutional births if cash transfer programs like the JSY are to improve health outcomes.
Exploring Quality of Care (QOC) from patients' and providers' perspectives in accessing Emergency Obstetric and Newborn Care (EmONC) services in hard-to-reach areas in Bangladesh

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ABSTRACT
Background: Although Bangladesh has made progress in achieving MDG 4 & 5 targets, neonatal and maternal mortalities are still very high. For further reduction of these deaths, the Govt. of Bangladesh has implemented a Maternal and Neonatal Health Initiative (MNHI) Program in certain hard-to-reach areas. This study was carried out to understand the program experiences, identify gaps in the intervention and examine QOC in facilities with EmONC service provision. By ‘QOC’, we meant timely and appropriate care through apposite interpersonal communication and appropriate privacy along with clean and adequate infrastructures and logistics support, which accelerate care-seeking, referral and follow-up visits. Methods: We conducted Key Informant Interviews with providers (132), observation of patients (41) and interviewed their family members (68) who sought care in these facilities. Results: Though human resource (HR) was one of the major interventions, the problem is still dire, especially in sub-district level. Providers’ shortage put extreme workload on the existing providers. This often deters them from delivering timely care and/or using unskilled support-staff for skilled activities. Extreme providers’ shortage results into poor safeguarding of privacy and poor interpersonal communication with patients/their family-members. All these dissuade continuation of treatments, follow-up visits and enrollment of further treatments. Certain logistics and infrastructures were improved, however, providers and management bodies still face problems offering timely and appropriate care due to poor supplies of consumables and poor maintenance system. Discussion and conclusion: While improved supplies of consumables and infrastructures addressed many underlying problems, HR gap was the core of many concerns for providing QOC services. We recommend an urgent initiative to fill-up the gaps in HR, especially with a 24/7 staff team trained in counseling which will guarantee proper interpersonal communication with clients. A package of such will ensure timely and appropriate care-seeking for EmONC services and strengthen people-centered health systems to promote greater responsiveness, better health, human rights and social justice.
Spaced education to improve quality of skilled birth attendance in India

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ABSTRACT

Background: Skilled birth attendance is critical for averting maternal and neonatal deaths, but factors including appropriate training and adequate health systems infrastructure affect its ability to reduce mortality. In Uttar Pradesh, which accounts for 28% of maternal/neonatal mortality in India, assessment of skilled birth attendants (SBAs) who received continuous 21-day training showed they did not achieve requisite competencies. The IntraHealth International-led Manthan Project (funded by the Bill & Melinda Gates Foundation) restructured SBA training into a spaced education design comprising four 'capsules' (4-7 days each) over six months. Capsules focused on core topics (e.g., antenatal care, postpartum hemorrhage), with time for participants to integrate skills and implement action plans at work. Methods: A randomized trial assessed feasibility and effectiveness of capsular training versus standard 21-day training. Participants, randomly allocated to two study arms, were observed for delivery skills pre- and post-training. Using a standardized checklist, investigators observed 232 and 202 deliveries at baseline and endline, respectively. Monthly facility audits in worksites in both study arms ensured availability of equipment and supplies to enable practice of newly acquired skills. Results: Net effects (difference of differences between study arms at baseline and endline) showed significant improvement in partograph use (14.4%**), reduction in unnecessary labor augmentation (-22.9%**), correct practice of active management of third stage of labor (32%***), newborn care practices, hand washing (41.4%**), and other infection prevention measures (**p<0.01, ***p<0.001) among SBAs trained through the capsular approach. Conclusions: Capsular training, with its focus on improving quality of SBA training and SBAs' ability to integrate skills and be supported in their worksites, facilitates transfer of knowledge and skills more effectively than continuous training and can significantly improve SBA performance. Results support evidence that spaced education formats that allow participants time to absorb knowledge and apply skills at work can improve knowledge and performance.
Evaluating quality-improvement processes and strategies: Experiences from central Mozambique

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ABSTRACT

Background: Prevention of mother-to-child HIV transmission (pMTCT) is complex, requiring that sequential, linked systems work well independently and together, and engage patients throughout the pMTCT cascade. A systems view can highlight inefficiencies at each step of the cascade, better explain how steps interrelate, and foster novel, iterative approaches to improve pMTCT and identify best practices for scale-up. Few rigorous evaluations have investigated the impact of systems analysis and improvement interventions in low-income countries. Methodology: A cluster randomized trial in 18 intervention and 18 control facilities split equally across three study countries with diverse histories, health systems, and HIV burden (Mozambique, Cote d'Ivoire, Kenya) is underway to assess the effectiveness of a five-step systems analysis and improvement intervention. The health facility-based intervention is a mentored process of 1. Cascade analysis with optimization functionality, 2. Process mapping, and 3-5. Continuous Quality Improvement (CQI) cycles of planning, implementing, analyzing, and re-iteration. Steps 1 and 2 are designed to identify and prioritize service areas for improvement (HIV testing, ART provision, postpartum care, PCR testing, pediatric cART initiation), and generate workflow modifications for testing. Steps 3-5 include the CQI cycle. The intervention will be evaluated over six months, focusing on process measures that reflect improved pMTCT efficiency and quality. Results: The five-step intervention was piloted over a six-month period in Mozambique, and significantly adapted to meet the needs and competencies of district-level nursing managers. Pilot results highlighted the importance of leadership and staffing patterns in implementation success. The pragmatic intervention trial will be completed in mid-2014, and main impact and process evaluation results will be presented. Discussion: This trial is a rigorous evaluation of a simple, iterative and contextually appropriate intervention to understand and improve pMTCT services. Results will provide evidence of its effectiveness, which may be applicable for testing in other similarly complex areas.
The role of the maternal and child health handbook as a people-centered health systems tool to earlier achievement of universal MCH coverage in Indonesia

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ABSTRACT

Backgrounds: The provision of appropriate maternal, newborn, and child health (MNCH) care services is the core strategy for achieving UN Millennium Development Goals 4 and 5. The Maternal and Child Health Handbook (MCHHB) is a paper-based personal health record in Indonesia. The MCHHB enables health workers to share records in providing care continuously along with MNCH, while increases family's self-governance on their health. This analysis aims to evaluate the relationship between MCHHB ownership and MNCH service utilization nationwide, while there is minimal data on the wide-scale impact of the MCHHB as a people-centered tool for national health systems. Methods: Nationally representative cross-sectional household data sets from the Indonesia Basic Health Surveys (RISKESDASs) were used to examine associations between MCHHB ownership and various factors indicative of health service utilisation. Results: The prevalence of MCHHB use increased across the nation from 2007 (38.4%), 2010 (55.2%) and 2013 (80.8%). Analysis of RISKESDAS 2010 data showed that MCHHB use was significantly associated with health personnel-assisted birth (adjusted odds ratio [aOR], 1.94; 95% confidence interval [CI], 1.73-2.18); the likelihood of obtaining birth weight measurement within the initial 48 hours (aOR, 2.82; 95% CI, 2.46-3.23); a continuum of pregnancy, delivery, and newborn care (aOR, 1.67; 95% CI, 1.44-1.93); and completion of measured child immunisations (aOR, 2.90; 95% CI, 2.46-3.41; aOR, 2.06; 95% CI, 1.76-2.41), even after the consideration of potential confounding factors. RISKESDAS2013 data traced birth planning records on MCHHB to confirm child birth preparedness. Conclusions: The association between MCHHB ownership and MNCH service utilisation suggests that the MCHHB may have facilitated the utilisation of services both at facilities and communities as a continuum. Integration of multiple vertical-program-specific records into a common tool is a possible realistic approach to ensure provision of essential MNCH services.
Association between health system performance and treatment outcomes in patients co-infected with MDR-TB and HIV in KwaZulu-Natal, South Africa: Implications for TB and MDR-TB programmes

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ABSTRACT

Objective: To improve the treatment of MDR-TB and HIV co-infected patients, we investigated the relationship between health system performance and patient treatment outcomes at 4 decentralised MDR-TB sites. Methods: In this mixed methods case study which included prospective comparative data, we measured health system performance using a framework of domains comprising key health service components. Pearson Product Moment Correlation coefficients quantified the direction and magnitude of the association between health system performance and MDR-TB treatment outcomes. Qualitative data from participant observation and interviews analysed using systematic text condensation (STC) complemented our quantitative findings. Results: We found significant differences in treatment outcomes across the sites with successful outcomes varying from 72% at Site 1 to 52% at Site 4 (p<0.01). Health systems performance scores also varied considerably across the sites. Our findings suggest a significant correlation between treatment outcomes and overall health system performance (r=0.99, p<0.01). The 'integration' domain, which measured integration of MDR-TB services into existing services appeared to have the strongest association with successful treatment outcomes (r=0.99, p<0.01). However, qualitative data indicated that the 'context' domain, measuring district and facility-level leadership and support influenced the other domains. Two routine human resource practices were shown to impact negatively on treatment outcomes: (1) The regular rotation of key clinical staff - the medical officer in the MDR-TB unit and the nurse-in-charge of the MDR-TB outpatients clinic. (2) The appointment of managers in an 'acting' capacity. Conclusion: We suggest there is an association between treatment outcomes and health system performance. To optimise successful treatment outcomes, district leadership must ensure that decentralised MDR-TB services are integrated into existing services and that front-line health care workers are supported. To ensure that the local context encourages the introduction of new programmes and facilitates implementation according to guidelines, regular monitoring and support at a district, facility and individual level are needed.
The inappropriate prescribing of antibacterial medicines in Sudan: a national study at national health insurance setting in 2012

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ABSTRACT

Background The irrational use of medicines is a common problem worldwide. Recent literature revealed that more than 50% of all medicines are prescribed inappropriately which results in serious public health problems like antimicrobial resistance. However, the extent of irrational antibacterials at National Health Insurance Fund (NHIF), Sudan is not well identified. Objective To determine the pattern of antibacterial medicines prescribing at primary healthcare facilities of NHIF, Sudan. Methods The study followed the method developed by the WHO/INRUD. Design: retrospective study Setting and study population: Twenty primary health centres were selected from 5 states that represented the five geographical regions of the Sudan, then 2401 patients encounters were withdrawn from these centres by systematic random sampling from the year 2012. Outcome measure(s): Medicines Prescribing Indicators. Results: On average the percentage of encounters with antibacterial is 64% (ranged from 43% in patients aged over 55 years, to 84% in children under five years old). The patient's age was negatively correlated with the percentage of encounters with an antibacterial prescribed ($r = -0.288$, $N = 2270$, $p < 0.01$, two tails), while there were no significant differences in prescribing behavior of doctors for males or females ($t = 0.919$, $p = 0.35$, two tails). The main causes of antibacterials prescribing were upper respiratory tract infections, urinary tract infections, typhoid fever and gastro-intestinal disorders. Interestingly, 45% of patients with malaria received antibacterials. Conclusion There is over use of antibacterials which reflects the urgent need for development and implementation of antibiotics policy and Standard Treatment guidelines especially for management of respiratory infections, urinary tract infections and typhoid fever.
The WHO emergency obstetric care indicators show increasing inequalities in availability and access to obstetric care in a high income country.

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ABSTRACT

Background: Several dimensions need to be included in evaluation of quality from a health systems perspective. Knowledge about how centralization of care affect maternal obstetric outcomes are lacking. We used the World Health Organization Emergency Obstetric and Newborn Care indicators (EmONC) to assess availability, access and quality of clinical care in a high income context. Methods: Population-based national registries were used. We designed two 1-year birth cohorts for 2000 (n=58632) and 2009 (n=61895), institutions were classified according to the EmONC signal functions and the indicator assessment was performed for each year. Further, travel distance to institution was assessed for women in fertile age on Jan 1 2000 (n=1050269) and 2010 (n=11227665) by combining census data and the national road database using GIS-software. Access to institutions was assessed by risk of unplanned delivery outside institution, and quality of clinical care was assessed using maternal morbidity as well as early perinatal mortality. Results: From 2000 to 2009 the national coverage of emergency obstetric care institutions decreased to a level below the population-based estimated need. Further, the coverage decreased below the estimated need in three of the five health regions. We found regional variations in the proportion of births outside EmOC-institutions and increasing regional variation in the cesarean section rate. Risk of maternal morbidity increased from 1.7 to 2.2% from 2000 to 2009, and in 2009 there were significant regional differences. The proportion of women living outside the 1-hour zone to all obstetric institutions and EmOC institutions increased from 2000 to 2010. Conclusion: The WHO EmONC indicators were useful and showed emerging inequalities in availability and access to EmOC institutions. Centralization was not associated with reduced risk of maternal morbidity. The combination of standard indicators and new geographic technology was useful in a high income country.
Report cards facilitate the quality improvement process for better maternal and newborn health in rural Uganda.

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ABSTRACT

Background: In the developing world, both demand (low utilization) and supply side (low quality or lack of services) factors present obstacles to effective implementation of interventions. The Expanded Quality Management using Information Power (EQUIP) project utilizes the Quality Improvement approach facilitated by locally generated data and population based data presented as report cards to enhance maternal and newborn. Objective: To assess the effect of report cards in facilitating the quality improvement process for better maternal newborn health in rural Uganda. Description of research study: EQUIP uses the collaborative QI approach. QI teams formed at health facility and community level work on different improvement topics within their scope of work. The choice of topics along the continuum of maternal newborn care, is guided by evidence from report cards generated from high quality continuous health facility and household survey data. The quarterly report card is a one pager on selected continuum of care indicators in line with the collaborative topic list, presented as run-charts or simple diagrams. These cards are tailored to suit specific audiences and presented as simple diagrams for community QI teams and more complex run charts for facility QI teams. The cards stimulate further thinking to generate change ideas for specific indicators worked on. Results: Since 2012, three report cards have been developed and used by the QI teams. These cards have triggered the development of feasible change ideas to improve antenatal care, health facility delivery, and postnatal care within Mayuge district. Preliminary results show an improvement in care practices such as 1st ANC visit (92% from 80%), birth preparedness (70% from <30%), health facility deliveries (60% from 29%) and PNC (10% from 1%). Conclusion: While QI teams monitor progress with locally generated data, the report cards provide population based data thus further stimulating QI work.
The GAVI alliance and the 'gates approach' to health system strengthening

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**ABSTRACT**

Background Lauded for their ability to get specific health issues onto national and international agendas and for their potential to improve value for money and outcomes, public-private global health initiatives (GHIs) today dominate global health governance. Yet, they have also been criticised for their negative impact on country health systems. In response, disease-specific GHIs have, somewhat paradoxically, appropriated the aim of health system strengthening (HSS). This paper critically analyses this development through an ethnographic case study of the GAVI Alliance, which funds vaccines in poor countries. By analysing the power GHIs have acquired to set the health systems agenda, it contributes to cutting-edge research on decision making in agenda setting and policy formulation.

**Methods**

This paper draws on ethnographic research conducted between 2010 and 2013 in London, New York, Geneva, Toronto and Oslo, including document review, observations at high-profile technical events, and in-depth interviews with 22 senior vaccination, health systems and public health experts. The findings have been analysed thematically in terms of shifting global health discourses, competitive professional pressures and global health history.

**Findings**

Despite a self-proclaimed 'single-minded' focus on vaccines, HSS support is fronted as a key principle of GAVI's mission. Yet, its meaning remains unclear and contested understandings of the health systems agenda abound within the epistemic community surrounding GAVI. These reflect entrenched tensions between competing public health ideologies and professional pressures that encourage disease-specific approaches. Contrary to broader conceptualisations of health system strengthening that emphasise social and political aspects, GAVI's HSS support has become emblematic of the so-called 'Gates approach' to global health, focused on targeted technical solutions with clear, measurable outcomes.

**Conclusion**

In spite of rhetoric in favour of 'holistic' health systems, GHIs like GAVI have come to capture the global health debate about health system strengthening in favour of their disease-specific approach and ethos.